HEALTH SECURITY ACT OF 1993—VOL. II

HEARINGS

BEFORE THE

COMMITTEE ON POST OFFICE AND CIVIL SERVICE HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 8 AND 24, 1994

Serial No. 103–32

Printed for the use of the
Committee on Post Office and Civil Service

U.S. GOVERNMENT PRINTING OFFICE
78–219 WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046076-X

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EFFECT OF H.R. 3600, HEALTH SECURITY ACT OF 1993, ON THE HEALTH BENEFITS OF POSTAL SERVICE EMPLOYEES

TUESDAY, FEBRUARY 8, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, DC.

The full committee met, pursuant to call, at 10 a.m., in room 311, Cannon House Office Building, Hon. William C. Clay (chairman of the committee) presiding.

Members present: Representatives Clay, Schroeder, Norton, Byrne, Gilman, and Morella.

Mr. CLAY. The committee will come to order. This morning, the committee holds its third hearing on the President's proposal to reform the Nation's health care system.

As a part of H.R. 3600, the administration has proposed that the Federal Employees Health Benefits Program be abolished, and that Federal employees and retirees be enrolled in State regional health alliances. More important, for the purposes of this hearing, the bill treats the Postal Service as a large employer, and provides it the option of operating a corporate alliance or enrolling its employees in regional alliances.

H.R. 3600 has very significant ramifications for the Postal Service and its employees. The bill would dismantle a program that has been an important and popular postal employee benefit for over 30 years. This in itself is a cause of great concern to postal employees as well as this committee.

As I have said on a number of occasions, I applaud the President's leadership on health care reform. I am a cosponsor of the administration's bill, and I have kept an open mind on his proposals for the FEHB Program. But I continue to have serious concerns with the proposal to dismantle a program that has worked so well for so long and for so many people.

On top of the threshold issue of whether or not to dismantle the FEHBP, there is another concern. The bill creates a corporate alliance option for the Postal Service, which brings with it a completely different set of policy and technical concerns associated with organizing and operating a corporate alliance. Consequently, the committee is extremely interested in the views of both postal employee and management organizations as well as the U.S. Postal Service. So, I look forward this morning to hearing their testimony.

[The prepared statement of Hon. William L. Clay follows:]

PREPARED STATEMENT OF HON. WILLIAM L. CLAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

This morning, the committee holds its third hearing on the President's proposal to reform the Nation's health care system.

As a part of H.R. 3600 the administration has proposed that the Federal Employees Health Benefits Program [FEHBP] be abolished and that Federal employees and retirees be enrolled in State regional health alliances. More important for the purposes of this hearing, the bill treats the Postal Service as a large employer and provides it the option of operating a corporate alliance or enrolling its employees in regional alliances.

H.R. 3600 has very serious implications for the Postal Service and its employees. First, the bill would dismantle a program that has been an important and popular postal employee benefit for over 30 years. This in itself is a cause of great concern to postal employees as well as this committee. As I have said on a number of occasions, I applaud the President's leadership on health care reform, I am a cosponsor of his bill and I have kept an open mind on his proposal for the FEHB Program. But I continue to have serious concerns with a proposal to dismantle a program that has worked so well for so long for so many people.

On top of the threshold issue of whether or not to dismantle the FEHBP, there is another. The bill creates the corporate alliance option for the Postal Service, which brings with it a completely different set of policy and technical concerns associated with organizing and operating a corporate alliance.

Consequently, the committee is extremely interested in the views of both the postal employee and management organizations as well as the U.S. Postal Service on H.R. 3600.

I look forward to this morning's testimony.

Mr. CLAY. Ms. Norton, do you have an opening statement?

Ms. NORTON. Yes, Mr. Chairman. I request that my formal remarks be included in the record, and I'd like simply to make——

Mr. CLAY. Without objection, so ordered.

Ms. NORTON. Thank you, Mr. Chairman. I'd like simply to welcome today's witnesses. Their testimony is critical for us not only as we look at the Postal Service jurisdiction itself, but I think it will inform us of much we don't know about how this planned President's bill will affect Americans at large.

The Postal Service has a plan that works better than most of the plans in the private sector. It is a plan that has attracted many outside of the Postal Service.

As we consider whether the option of its own corporate alliance is best for the Postal Service, we have to keep in mind all of the implications of that, and we cannot know all of them unless we probe very deeply, as I hope that today's hearing will. For example, there is to be a 1 percent payroll assessment on corporate alliances, that they will pay the Federal Government.

When we look at the Postal Service and how we scramble every year for its budget, one is left to wonder about the effect of such an assessment. Above all, Mr. Chairman, I believe that the opportunity for reform that all should not become an excuse for the reduction of the benefits of postal employees. These benefits, after all, are in lieu of wages, and we must bear that in mind as we consider the various options open to them.

I want to welcome my good friends who will be testifying this morning. Thank you, Mr. Chairman.

[The prepared statement of Hon. Eleanor Norton follows:]

PREPARED STATEMENT OF HON. ELEANOR HOLMES NORTON, A REPRESENTATIVE IN CONGRESS FROM THE DISTRICT OF COLUMBIA

Although postal employees currently participate in the Federal Employees Health Benefits Plan (FEHBP), the Health Security Act provides that the Postal Service

may elect to create its own "corporate" health care alliance and that therefore postal employees, unlike all other Federal employees, would not have to participate in their respective regional alliance. As I see it, however, there are critical issues that the Postal Service and its unions must confront if it intends to establish its own corporate alliance. For example, what will be the impact on the Postal Service, already scrambling to keep up with its competition, of the one percent payroll assessment that corporate alliances must pay to the Federal government? Given the effect of community ratings on premium costs, what will be the impact on the risk pool of the loss of non-postal Federal employees who currently participate in some of the Postal Service's health care plans? Let me emphasize that regardless of whether a Postal Service alliance is established, we must not allow the occasion of a much desired reform to become an opportunity to reduce health benefits of postal employees.

I welcome today's witnesses and look forward to hearing your testimony.

Mr. CLAY. Thank you. The first panel this morning will consist of Mr. Moe Biller, president of the American Postal Workers Union; Mr. Vincent Sombrotto, president, National Association of Letter Carriers; Mr. William Brown, Jr., president, National Rural Letter Carriers Association; and Mr. Mark Gardner, Secretary-Treasurer of the Mailhandlers' Union.

Gentlemen, welcome to the committee. Your statements, without objection, will be entered into the record in their entirety, at this point, and you may proceed as you so desire.

STATEMENTS OF MOE BILLER, PRESIDENT, AMERICAN POSTAL WORKERS UNION, AFL–CIO; VINCENT SOMBROTTO, PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS, AFL–CIO; WILLIAM BROWN, JR., PRESIDENT, NATIONAL RURAL LETTER CARRIERS ASSOCIATION; AND MARK GARDNER, SECRETARY-TREASURER, MAILHANDLERS' UNION, LIUNA, AFL–CIO

Mr. BILLER. Good morning, Chairman Clay and members of the committee. My name is Moe Biller, president of the American Postal Workers Union, AFL–CIO, 350,000 postal employees in every State and territory of the United States. We are also sponsors and operators of a very large health insurance program, the APWU Health Plan, which is a part of the Federal Employees Health Benefits Program. The APWU Health Plan covers approximately 260,000 individuals. We process more than 3.5 million claims each year and pay out claims amounting to nearly $500 million per year.

The APWU is extremely proud of its long tradition of providing health benefits for its members. This tradition of service to our members began long before there was even a Federal Employees Health Benefits Program.

The APWU is here today to express its strong support for principles embodied in the Health Security Act as proposed. I want to emphasize, however, that we believe that the best solution for the Nation's health benefits problems would be a single-payer system of health insurance. We consider it very important, therefore, that the provisions of this bill that permit States to establish single-payer systems be included in the final legislation.

The Health Security Act is bold, progressive, and historic legislation. I mean it as high praise when I say that the legislation proposed by President Clinton is worthy of the historic problem it confronts—the urgent need to provide comprehensive health care for all Americans on a cost-effective basis.

I must emphasize, however, that our endorsement and support for the Health Security Act is conditioned on complete protection of benefits presently provided to active and retired postal and Federal employees, and preservation of our right to employer premium contributions at the levels we have achieved through collective bargaining.

For example, one problem with the Health Security Act benefits as proposed is the imposition of a $250 per person prescription drug deductible. This is not sufficient coverage for prescription drugs. This is a significantly higher deductible than required under any FEHB Plan.

Supplemental benefits where needed to maintain existing benefits must also be readily available and affordable. The supplemental benefits program developed by OPM for FEHBP beneficiaries must be provided to postal employees. These aspects of the Health Security Act must be in the legislation for it to have our support.

The Health Security Act appropriately preserves rights established under collective bargaining agreements, and recognizes the obligation of the U.S. Postal Service to bargain to agreement with unions representing its employees on the issue of health benefits, including the right to establish a separate Postal Service corporate alliance.

Because the FEHBP would not be terminated until 1998 under the proposed legislation, there can be no justification for imposing a 1 percent of payroll assessment on the Postal Service before that date. Even then, and particularly if the FEHB Program is to be continued, we question the appropriateness of placing the assessment on the Postal Service.

Under the Postal Reorganization Act, the APWU has the right to bargain for health benefits in addition to those provided by the Federal Employees Health Benefits Program. The APWU has used this bargaining right to achieve a larger Postal Service contribution to health benefit premiums than is provided for Federal employees under the FEHBP.

The Postal Reorganization Act also includes another important protection for postal employees that must be a part of this legislation. It provides that the package of fringe benefits provided to postal employees through the operation of the collective bargaining provisions of the Postal Reorganization Act may not, overall, be less favorable to postal employees than benefits in effect on the effective date of the act. This important protection must be preserved for postal employees if we are to continue to support enactment of legislation which would change the way health benefits are provided to postal workers.

Another aspect of FEHBP that must be preserved for postal employees is the inclusion of part-time postal workers in the same plan as full-time postal workers. Under our collective bargaining agreement, the Postal Service is required to provide full benefits for career part-time workers.

Because most career part-time postal workers have flexible schedules, their hours vary considerably. If they were to be required to change health plans every time their hours fluctuated, it would be a hardship for them and would create an administrative

burden. For these reasons, part-time postal employees should be enrolled in the same plan as full-time postal workers.

We are extremely proud of the APWU Health Plan. Our health plan offers a comprehensive benefit package—comparable to the benefit package provided by the Health Security Act—at premiums which are reasonable and very competitive with those charged by other plans in the FEHB Program. The APWU Health Plan has accomplished this by using state-of-the-art methods for managing an indemnity benefit plan. In this respect, we are comparable to the well-managed private sector indemnity benefit plans.

Our plan includes a preferred provider organization network; prescription drug programs; utilization review programs, including precertification of hospital stays and large case management; electronic claims processing, and computer imaging.

In recent years, the FEHB Program has experienced relatively low increases in premium rates. For years 1990 through 1993, the average contribution paid by the Postal Service has gone up on average only 8.4 percent per year. This is significantly less than private-sector trend increases. If we are to move to a different method of delivering benefits to Federal and postal workers, we must be sure that the advantageous features of the FEHBP that have permitted this performance are not lost.

The FEHB Program has not been free of controversy and difficulty over the years. Problems remain with the FEHB Program. The big six formula for setting premium contributions is flawed and has not reflected increases in the cost of medical care within the FEHB Program. A better formula would be one which prospectively adjusts to reflect overall cost increases in the program.

Another problem with the FEHB Program is that it permits adverse selection. Older, high risk, or costly members tend to be more prevalent in some plans than in others, but payments to plans do not account for this adverse selection. This means that some plans have been permitted to skim low-risk members while other plans bear the burden of providing for the older and less healthy membership. Under the FEHBP, payments should reflect demographic and other risk differences between plan memberships.

A related problem is that benefits are not standardized at an appropriate level. Some low-cost FEHB plans have been permitted to offer inadequate benefits that do not adequately cover the cost of service in all areas of the country. FEHBP benefits need to be standardized so that all plans offer comprehensive benefits that are adequate in all parts of the country. For example, carriers have not been permitted to improve dental benefits.

In summary then, let me say these things: There can be no going backward in the protections for the people we represent. Universal coverage and comprehensive health care reform is long overdue. We endorse these concepts and praise the Clinton administration for proposing the Health Security, which will include 37 million workers that are presently not covered.

It is absolutely essential that benefit levels for Federal and postal employees be protected. The so-called comprehensive benefits under the bill must not be allowed to fall below current FEHBP benefits; and, equally important, supplemental benefits must be

provided for Federal and postal workers, to cover such things as dental benefits.

Part-time employees must be included in the same plan as full-time postal workers. Particular emphasis must be given to protection for retired postal and Federal workers not only for current retirees, but for all future retirees.

Postal retirees are presently enrolled in the FEHBP. The proposed shift of retirees into regional alliances, if it is to occur, must be accompanied by a guarantee that they receive health benefits at least as good as they receive in the FEHBP, at a comparable cost.

Furthermore, early retirees in the FEHB, aged 55 to 65, must be treated no less favorably than early retirees working for other corporations that provide early retiree health care coverage. This is crucial.

Retirees over age 65 now receive 100-percent reimbursement for health care costs through a combination of Medicare and FEHBP insurance. That opportunity must continue to exist for all annuitants, regardless of whether they become annuitants before or after the passage of this legislation.

It is also essential that the Health Security Act preserve our collective bargaining rights under the Postal Reorganization Act, including the right to have the Postal Service treated as a separate corporate alliance.

Any change in the Federal Employees Health Benefits Program must include provisions that protect benefit levels and premium contributions. If the FEHBP is to be preserved, the changes I have just recommended in premium adjustment formulas, minimum benefits, and risk adjustment must be made.

FEHBP reserves attributable to postal workers must continue to be held or applied for the benefit of postal workers. We subscribe fully to the AFL–CIO principles of universal coverage, cost containment, quality of service, and fair and affordable premiums.

As I have said before, APWU will support no plan that attempts to reduce what we have at present, for both workers and retirees.

With the committee's permission, I will submit for the hearing record an evaluation of the benefits provided under the Health Security Act as compared with the largest plan in the FEHB Program, the Blue Cross Standard Program. As you will see, the benefits provided under the Health Security Act are, overall, very comparable in value. That is an absolutely essential part of this legislation. Without guaranteed comprehensive benefits, this legislation will not be supported and should not be passed.

I am available to answer any questions you may have. I thank you for this opportunity.

[The prepared statement of Mr. Biller follows:]

PREPARED STATEMENT OF MOE BILLER, PRESIDENT, AMERICAN POSTAL WORKERS UNION, AFL–CIO

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For example, one problem with the Health Security Act benefits as proposed is the imposition of a $250 per person prescription drug deductible. This is not sufficient coverage for prescription drugs. This is a significantly higher deductible than required under any FEHB plan.

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The FEHB Program has not been free of controversy and difficulty over the years.

Problems remain with the FEHB Program:

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A related problem is that benefits are not standardized at an appropriate level. Some low-cost FEHB plans have been permitted to offer inadequate benefits that do not adequately cover the cost of service in all areas of the country. FEHBP benefits need to be standardized so that all plans offer comprehensive benefits that are adequate in all part of the country. For example, carriers have not been permitted to improve dental benefits.

In summary, then, let me say these things: There can be no going backward in the protections for the people we represent.

Universal coverage and comprehensive health care reform is long overdue. We endorse these concepts and praise the Clinton Administration for proposing the Health Security Act.

It is absolutely essential that benefit levels for Federal and postal employees be protected. The so-called "comprehensive benefits" under the bill must not be allowed to fall below current FEHBP benefits; and—equally imprtant—supplemental benefits must be provided for Federal and postal workers, to cover such things as dental benefits.

Part-time employees must be included in the same plan as full-time postal workers.

Particular emphasis must be given to protection for retired postal and Federal workers, not only for current retirees, but for all future retirees. Postal retirees are presently enrolled in the FEHBP. The proposed shift of retirees into regional alliances, if it is to occur, must be accompanied by a guarantee that they receive health benefits at least as good as they receive in the FEHBP, at a comparable cost. Furthermore, early retirees in the FEHBP (aged 55 to 65) must be treated no less favorably then early retirees working for other corporations that provide early retiree health care coverage. This is crucial.

Retirees over age 65 now receive 100 percent reimbursement for health care costs through a combination of Medicare and FEHBP insurance. That opportunity must continue to exist for all annuitants, regardless of whether they become annuitants before or after the passage of this legislations.

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With the Committee's permission, I will submit for the Hearing Record an evaluation of the benefits provided under the health Security Act as compared with the largest plan in the FEHB Program, the Blue Cross Standard program. As you will

see, the benefits provided under the Health Security Act are, overall, very comparable in value. That is an absolutely essential part of this legislation. Without guaranteed comprehensive benefits, this legislation will not be supported and should not be passed.

I am available to answer any questions you may have.

February 8, 1994

COMPARISON OF FEHB BLUE CROSS STANDARD PLAN BENEFITS TO BENEFITS UNDER THE HEALTH SECURITY ACT (HSA) INTRODUCED BY PRESIDENT CLINTON

The attached chart compares the benefits under the Health Security Act (HSA) to the benefits under the FEHB Blue Cross Standard Plan. It assumes that the employee would be covered under a Combination Cost Sharing Plan under HSA so that:

- in-network benefits under the Blue Cross plan are compared to the Lower Cost Sharing benefits and
- out-of-network benefits under the Blue Cross Standard plan are compared to the Higher Cost Sharing benefits

IN-NETWORK MEDICAL BENEFITS

The chart illustrates that in almost every area, Lower Cost Sharing medical benefits are higher than the in-network medical benefits under the Blue Cross Standard Plan. The advantages to employees under HSA are:

- no in-network deductibles
- the out-of-pocket maximum per person is lower and applies to a broader range of services (specifically inpatient mental and nervous and dental care for children);
- coinsurance paid by the employee is less, and;
- new benefits, such as children's eye glasses, and vision and hearing tests are added.

OUT-OF-NETWORK MEDICAL BENEFITS

Medical benefits under the HSA Higher Cost Sharing Plan generally will exceed Blue Cross Standard out-of-network medical benefits due to lower coinsurance, the lower out-of-pocket limit per person and the additional routine medical, vision and hearing benefits.

There are, however, exceptions:

- Inpatient Hospital Expenses

  HSA would cover inpatient hospital expenses provided out of network at 80%. The Blue Cross Standard Plan covers these expenses at 100% after a $250 per admission deductible.

While HSA appears to provide significantly less coverage, there are two offsetting factors:

- Many individuals who are hospitalized have significant other medical expenses for surgeons, physicians, etc. Their additional hospital coinsurance under HSA will be offset to some extent by lower coinsurance for these other expenses (20% in HSA compared to 25% in Blue Cross). In addition, HSA would limit doctor's charges, so patients would not be subject to charges in excess of R&C.

- A large proportion of people who are hospitalized under HSA will reach their out-of-pocket maximum; these individuals will have a per person out-of-pocket limit of $1,500 under HSA compared to $3,250 under Blue Cross Standard. (However, if two or more persons in a family have large medical expenses, the family out-of-pocket limit will be similar under both plans).

- Out-of-network Drug Benefits

Under Blue Cross Standard Plan, the out-of-network prescription drug benefit is 60% after a $50 deductible. This compares to 80% after a $250 deductible under HSA.

For an individual whose out-of-network drug expenses amount to less than $850 per year, the Blue Cross Standard plan would clearly be better. On the other hand, an individual whose out-of-network drug expenses exceed $850 per year would be better off under HSA.

- Mental Health and Substance Abuse Benefits.

The mental health and substance abuse benefits provided under HSA are, in general, better than the Blue Cross Standard plan, particularly if the individual goes in-network.

However, both plans have strict limits that would impact individuals differently. The Blue Cross Standard Plan has lifetime limits as compared to HSA's annual limits. Lifetime limits under Blue Cross Standard for mental health and substance abuse are (i) $50,000 maximum benefit and (ii) one inpatient treatment (max 28 days) for substance and drug abuse. HSA has an annual 30 day inpatient limit (additional days are allowed only in very limited situations or if a non-residential program is used). Under FEHB, an individual who had used up his lifetime limit under Blue Cross Standard would be forced to enroll in a new plan to have continued coverage.

Both plans limit outpatient visits. Blue Cross Standard Plan limits visits to 25 per year. HSA limits depend on the type of visit. For example, psychotherapy and collateral visits are limited to 30 visits per year but crisis services, screening and diagnosis and case management are not limited at all.

DENTAL BENEFITS

Until the year 2001, the major loss under the Health Security Act will be adult dental benefits. This is especially true for individuals who have little need for medical benefits in a specific year, but regularly use preventative and restorative dental benefits.

Under HSA, adult dental benefits will not be covered until 2001. However beginning in 2001, HSA's covered services for both adults and children will represent an improvement over the Blue Cross Plan since HSA will then include periodontics for adults, endodontics and limited orthodontics for children, and the proposed coinsurance / copays will be less.

Employers are permitted to supplement the dental benefits provided under HSA. Since most employers' dental plans now cover significantly more than even the proposed HSA plan for 2001, we believe many of these employers will provide supplementary dental benefits. Clearly, this is an area that will need to be addressed with employers in FEHBA.

VALUE OF THE PLAN

The value of a set of plan benefits from an employee perspective is clearly dependent on the type of services and amount of services used by that employee and his/her family. When benefits change, some employees will be adversely affected and some will be better off.

HSA stresses protection against catastrophic expenses and availability of coverage. From a financial security point of view, major enhancements include the lower out-of-pocket maximums per person, the guaranteed availability of coverage and the controls on what providers can bill. This has to be weighed against such things as the additional coinsurance on short hospital stays and the higher drug deductible which would not pose a major threat to their financial security.

In summary:

- Assuming dental benefits are supplemented, the benefits under the HSA Combination Cost Sharing plan will be very comparable to the value of benefits under the Blue Cross Standard Plan. HSA would be more valuable if in-network benefits are extensively used. While this is true on average, the impact on individuals may be different.

- The value of HSA to employees will depend on the employee contributions required. Clearly, the mandated level of employer contributions are higher for federal employees in FEHBA but not for postal employees.

- Whether HSA will ultimately cost the employee and employer more will depend on the impact Health Care Reform has on overall utilization of health care services by employees and the population in general, and also on the way the premium burden for Medicaid and other programs is shifted to employees and employers.

COMPARISON OF MEDICAL BENEFITS

	IN - NETWORK		OUT - OF - NETWORK	
	Blue Cross Standard	HSA: Lower Cost Sharing	Blue Cross Standard	HSA:Higher Cost Sharing
REASONABLE & CUSTOMARY LIMITS:	Not Applicable	Not Applicable	Applied	Not Applicable
DEDUCTIBLES:				
• General per person (max. 2 family)	$200	None	$200	$200
• Hospital per admission	None	None	$250	None
• Drug	$50	None	$50	$250
OUT-OF-POCKET LIMITS:				
• Per person	$2,500	$1,500	$3,250	$1,500
• Max. per family	$2,500	$3,000	$3,250	$3,000
% PAID BY PLAN / COPAY PAID BY EE:				
• Hospital - Inpatient	100%	100%	100%	80%
- Outpatient	100% & 95%	100% / $10 & $25	75%	80%
• Medical - Inpatient	95%	100% / $10	75%	80%
- Outpatient	100% / $10	100% / $10	75%	80%
• Surgical	95%	100% / $10	75%	80%
• Diagnostics	95%	100%	75%	80%
• Drugs	80%	100% / $5	60%	80%

Foster Higgins

COMPARISON OF MEDICAL BENEFITS (continued)

	IN - NETWORK		OUT - OF - NETWORK	
	Blue Cross Standard	HSA: Lower Cost Sharing	Blue Cross Standard	HSA: Higher Cost Sharing
WELLNESS BENEFITS:				
• Physicals	100% / $10	100%	No	100%
• Mammograms, Pap Smears, Cholesterol	100%	100%	75%**	100%
• Pre-Natal Care	95%	100%	75%	100%
• Well-Baby/Child	100%	100%	100%	100%
• Eye/Hearing Exams	No	100% / $10	No	80%
• Eyeglasses for Children	No	100%	No	80%
MENTAL & NERVOUS / SUBSTANCE ABUSE:				
• Inpatient - Hospital - Doctors	60% 60%	100% 100% / $10	60% after $250 deductible	80% after day one
• Outpatient - Psychotherapy/collateral - Other	60% 60%	100% / $25 100% / $10	60% 60%	50% 80%
• Out-of-Pocket Limits	No cost-sharing applied to out-of-pocket maxmimum	Inpatient cost-sharing applied to out-of-pocket maximum	No cost-sharing to out-of-pocket maximum	Inpatient cost-sharing applied to out-of-pocket maximum.
• Maximum Benefits	Lifetime maximums Annual outpatient visit maximums	Annual inpatient day limit Annual outpatient visit maximums	Lifetime maximums Annual outpatient visit maximums	Annual inpatient day limit Annual outpatient visit maximums

** Test only, not visit.

Mr. CLAY. Thank you.
Mr. Sombrotto.
Mr. SOMBROTTO. Thank you very much.

Chairman Clay and members of the committee, I am Vincent R. Sombrotto, National President of the National Association of Letter Carriers, AFL–CIO. On behalf of the 307,000 active and retired members of the NALC, I am pleased to share with you the letter carriers' perspective on the President's bold plan to provide all Americans with comprehensive health coverage, the Health Security Act.

The NALC, like the AFL–CIO, strongly supports the President's proposal to reform the American health care system to become more accessible, affordable, and accountable. This legislation offers an opportunity for genuine reform of the system by providing for universal coverage, comprehensive benefits, choice of plan and provider, quality, and fair financing. The NALC urges Congress to enact the President's Health Care Plan and reject any alternative proposals that do not guarantee these necessary elements and masquerade as reform.

The Health Security Act presented to the Congress in October represents a dramatic departure from the clumsy patchwork system of today. The President and Mrs. Clinton have recognized the basic inequities inherent in today's system, where millions of families are one illness away from impoverishment; where insurance companies can shun people who need coverage the most, or price them out of the market; a system that provides more coverage for treatment of disease than prevention of disease. The American Labor Movement has consistently advocated universal and comprehensive health coverage reform not unlike the one now proposed by the White House. The critical features of reform I noted above—universal coverage, comprehensive benefits, choice of plan and provider, quality, and fair financing—are fundamental elements of the President's plan, and for that reason the NALC supports it.

For over 30 years, postal and Federal employees have depended upon the Federal Employees Health Benefits Program, FEHBP, for health care coverage. As a union, we have bargained for an affordable employee premium contribution. We have also participated as a plan sponsor to ensure that postal employees have available comprehensive coverage at affordable rates. However, FEHBA has not been spared the problems that have plagued the health care system as a whole.

In past appearances before this committee, we have expressed our views on the need for reform of FEHBP, and the committee has, over the years, received a lot of professional advice about the structural problems that have developed over the course of the program. We regret that there has been no significant progress toward reform of FEHBA. All the prior administrations were able to come up with were across-the-board benefit cuts, which we vigorously opposed, and some efforts to establish cost-containment programs.

Therefore, the time is right for us to support a comprehensive plan to improve health benefits for the entire Federal work force, a plan that would maintain the stability of enrollee contributions, provide a fair Government contribution, and disentangle the premium formula from the annual budget process.

Let me be specific about some of the flaws in the FEHBP program that would be remedied by the President's plan. Like the typical American family, many members of the postal family are without affordable health insurance coverage. FEHBA has major gaps in coverage which leave large numbers of individuals without true health security. For example, casual and transitional employees are not entitled to coverage in FEHBA because they work for less than the minimum tour required under the statute. Regrettably, the Postal Service has started down the path toward a two-tiered work force—a career work force entitled to full benefits collectively bargained by the parties, and a transitional work force which does not get health benefits. Currently, transitional and casual employees comprise 10 percent of the entire postal work force.

While we adamantly oppose a two-tiered work force, as long as the Postal Service hired casual and transitional employees they should be entitled to the same health benefits enjoyed by the career work force. The President's proposal addresses this egregious inequality. Under the Health Security Act, all employees, including casuals and transitional, would be entitled to comprehensive health coverage.

Retirees who have not satisfied the 5-year rule are also excluded from coverage under FEHBA. Employees who have not had 5 years of uninterrupted service prior to separation, for example, as a result of a reduction-in-force or a reorganization, employees are not entitled to coverage in FEHBP when they retire. Under the President's plan, all retirees have secure coverage either in an enhanced Medicare program or through the health alliances.

As you know, in FEHBP, the postal worker's portion of the premium increases significantly when he or she retires. Under the Health Security Act, a retiree-subsidy pool will pay 80 percent of the premium and the employer will contribute the remaining share for pre-Medicare retirees. As a result, these retirees would pay no premium costs. This would be an appropriate recognition for NALC retirees and all Federal retirees. Those retirees who then join Medicare will find improved benefits with the addition of long-term care and prescription drug benefits.

Dependents of postal and Federal employees who have reached their 22d birthday or begin their own families, although entitled to 36 months of continued FEHBP coverage, lose the Government contributions toward their premium. This means that our children are confronted with the prospect of paying the entire FEHBP premium, or foregoing health coverage. Many of our kids have difficulty finding their first job, and many have employers who do not feel obligated to offer health coverage. These members of our families are without the health insurance security that the President's proposal would provide.

The President's proposal would also eliminate the confusion that results during open season when employees and retirees must evaluate all of the different plans and types of plans in order to determine what is really being offered. The dozen or so fee-for-service plans and hundreds of HMO's do not offer the same benefits and there is a wide variation in cost. These cost variations may not reflect differences in benefits.

The comprehensive benefit package in the President's plan is a standard benefit package, not unlike the recommendations made by past FEHBP studies. Each of the three types of plans offered to individuals and families must provide the same comprehensive plan. Thereby, plans would be forced to compete against one another on the basis of quality, efficiency, and cost.

By standardizing the benefits package and community rating the entire beneficiary pool, the problem of adverse selection which has plagued FEHBP would be eliminated. In fact, the standard comprehensive benefit package is the most significant feature of the President's plan to NALC members.

In FEHBP, our members have become accustomed to a certain level of benefits. Our own study of the comprehensive benefit package in the President's plan has shown that the level of benefits under the Health Security Act is at least as favorable, if not more generous, than the benefits now offered by our own health plan and some of the other fee-for-service plans favored by postal employees.

We know that some of the Federal unions have expressed concern about the level of hospital coverage in the President's plan. I am reporting on what our own studies have shown about the overall level of benefits rather than specific coverage provisions.

We applaud, and insist upon, a benefit package that, at least, maintains what our members have now. I want to mention, in particular, preventive health care and mental health coverage, two types of benefits which are seriously short-changed in FEHBP, and which are given much greater attention, are provided for in the President's plan.

Under the President's proposal, FEHBA would be eliminated and Federal employees would obtain coverage through health alliances. In many respects, the procedure for choosing a plan under the Health Security Act is similar to the manner in which Federal employees now choose plans in FEHBP, with the health alliances taking on some of the functions now performed by OPM.

We know that the ability of certain groups, including the Postal Service, to form their own health alliances under the Health Security Act is one feature of the President's proposal that has generated some discussion, and I would like to take a moment to express our views on this subject.

The Postal Service, with nearly 820,000 employees, is the Nation's largest civilian employer. However, the Postal Service is financially and operationally independent of the rest of the Government. Furthermore, the Postal Service is the only Government entity whose employees enjoy, by law, full collective bargaining rights, including the right to bargain over health coverage. In fact, the Postal Reorganization Act has always provided the Postal Service and its unions with the opportunity to bargain for a separate postal plan.

We commend the President for recognizing that the Postal Service shares many of the characteristics of large private sector employers that collectively bargain with their employees by including the Postal Service among the entities that can, through collective bargaining, form a health alliance.

Although I have stressed our support for the Health Security Act and indicated the ways in which we believe the proposal will eliminate the problems experienced in FEHBP, I do not want to leave you with the impression that we view the President's proposal as perfect. For example, we are concerned about some provisions that could make it more difficult to maintain the voice we, as a union, now have in ensuring comprehensive, affordable coverage.

The President's plan imposes some obstacles on entities that may choose to form health alliances. There are financial and administrative disincentives to forming a health alliance that are magnified enormously if applied to the Postal Service. As an employer of over 800,000 people operating in 10,000 locations nationwide, for example, the NALC believes that the 1 percent payroll assessment levied against corporate alliances under the President's plan unfairly burdens the Postal Service. Bear in mind that the Postal Service has been strained by the $6.9 billion in costs associated with budget legislation over the past 10 years. The Congress should not merely acquiesce in the application of this assessment to the service.

In addition, although we favor federally-sponsored Medicare supplemental benefits for retirees, the President's plan does not guarantee this benefit to all retirees. The eligibility of future retirees is uncertain. We urge the Congress to remedy the disparate treatment among retirees.

And I might add here that in our union, a great number of our retirees suffer under a very, very difficult situation as it relates to Medicare Part B. Our union plan, for many years, did not require a retiree, after age 65, to belong to Part B, and we provided those benefits free for almost 25 years. And then OPM said that we had to be in line with all the rest of the plans and that our members had to be covered by Part B. And, of course, there is a penalty associated if you didn't join when you reached the age 65, and many of our members pay 100 percent over the premium, and their annuities are not that great, and it's an enormous burden.

We had some legislation passed 2 years ago, through the Ways and Means Committee, that would limit the exposure to 25 percent and, of course, President Bush at that time vetoed that bill. We would hope that this Congress would look at the opportunity to revisit that situation, for those that are so hurt by this situation of a penalty of 10 percent a year.

We hope to work with the Congress as the process goes forward to address some of the anomalies in the bill.

We are also concerned about the transition period during which FEHBP would continue to cover Federal employees until they are integrated into the new alliance system. It is imperative that the program and the costs of the plans remain stable during this period.

The protection of the proxy-premium is one measure that would lend stability to the program during a transition, and we urge you to support it. We all understand and are aware of the fact that the President's budget proposal does not contain what is generally called the Phantom Plan, and we would strongly, strongly, in the most strongest terms, urge you all to support the continuance of the proxy plan.

Finally, I want to express our concern about recent reports in the press that too many of the important features of the bill may fall away during the legislative process. These reports focus on proposals introduced as alternative plans and rumors of backsliding by the administration.

What is most mystifying about the debate so far on this issue is that a number of those sponsoring alternative proposals assume there is no health care crisis. The sponsors of these plans, apparently satisfied with slower medical inflation in the past couple of years, have put blinders on.

The 39 million Americans who are uninsured, the 2 million Americans who lose health insurance months, and the millions of Americans who live with the insecurity of not knowing whether their health insurance is adequate or whether it will be there when they need it, disagree.

We are committed to supporting reform that guarantees comprehensive benefits, universal coverage, fair pricing, and responsible cost containment. We will not stand by and watch this reform proposal whittled down to something beyond recognition. We will not accept erosion or elimination of significant elements like the comprehensive benefit package, security for retirees, or universal coverage.

We are supporting this plan because it contains all of the features we believe are critical for genuine reform. I hope the Congress will place itself squarely behind the President and commit to passage of this proposal.

Thank you, Mr. Chairman, and I'll accept any questions and try to answer them.

[The prepared statement of Mr. Sombrotto follows:]

PREPARED STATEMENT OF VINCENT SOMBROTTO, PRESIDENT, NATIONAL ASSOCIATION OF LETTER CARRIERS, AFL–CIO

Chairman Clay and members of the committee, I am Vincent R. Sombrotto, National President of the National Association of Letter carriers, AFL–CIO [NALC]. On behalf of the 307,000 active and retired members of the NALC, I am pleased to share with you the letter carriers' perspective on the President's bold plan to provide all Americans with comprehensive health coverage, the Health Security Act.

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The Health Security Act presented to Congress in October represents a dramatic departure from the clumsy patchwork system of today. The President and Mrs. Clinton have recognized the basic inequities inherent in today's system, where millions of families are one illness away from impoverishment; where insurance companies can shun people who need coverage the most, or price them out of the market; a system that provides more coverage for the treatment of disease than for prevention of disease. The American labor movement has consistently advocated universal and comprehensive health coverage—reform not unlike the one now proposed by the White House. The critical features of reform I noted above, universal coverage, comprehensive benefits, choice of plan and provider, quality, and fair financing, are fundamental elements of the President's plan and for that reason the NALC supports it.

For over 30 years, postal and Federal employees have depended upon the Federal Employees Health Benefits Program [FEHBP] for health care coverage. As a union, we have bargained for an affordable employee premium contribution. We have also

participated as a plan sponsor to ensure that postal employees have available comprehensive coverage at affordable rates. However, FEHBA has not been spared the problems that have plagued the health care system as a whole. In past appearances before this committee, we have expressed our views on the need for reform of FEHBP, and the committee has, over the years, received a lot of professional advice about the structural problems that have developed over the course of the program. We regret that there has been no significant progress toward reform of FEHBA. All the prior administrations were able to come up with were across-the-board benefit cuts (which we vigorously opposed), and some efforts to establish cost containment programs. Therefore, the time is right for us to support a comprehensive plan to improve health benefits for the entire Federal work force—a plan that would maintain the stability of enrollee contributions, provide a fair Government contribution, and disentangle the premium formula from the annual budget process.

Let me be specific about some of the flaws in the FEHBP Program that would be remedied by the President's plan. Like the typical American family, many members of the postal family are without affordable health insurance coverage. FEHBA has major gaps in coverage which leave large numbers of individuals without true health security. For example, casual and transitional employees are not entitled to coverage in FEHBA because they work for less than the minimum tour required under the statute. Regrettably, the postal service has started down the path toward a two-tiered work force: A career work force entitled to full benefits collectively bargained by the parties, and a transitional work force which does not get health benefits. Currently, transitional and casual employees comprise 10% of the entire postal work force. While we adamantly oppose a two-tiered work force, as long as the Postal Service hires casual and transitional employees, they should be entitled to the same health benefits enjoyed by the career work force. The President's proposal addresses this egregious inequality. Under the Health Security Act, all employees, including casuals and transitional, would be entitled to comprehensive health coverage.

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Finally, I want to express our concern about recent reports in the press that too many of the important features of the bill may fall away during the legislative process. These reports focus on proposals introduced as alternative plans, and rumors of backsliding by the administration. What is most mystifying about the debate so far on this issue is that a number of those sponsoring alternative proposals assume there is no health care crisis. The sponsors of these plans, apparently satisfied with slower medical inflation in the past couple of years, have put blinders on. The 39 million Americans who are uninsured, the 2 million Americans who lose health insurance each month, and the millions of Americans who live with the insecurity of not knowing whether their health insurance is adequate or whether it will be there when they need it, disagree.

We are committed to supporting reform that guarantees comprehensive benefits, universal coverage, fair pricing and responsible cost containment. We will not stand

by and watch this reform proposal whittled down to something beyond recognition. We will not accept erosion or elimination of significant elements like the comprehensive benefit package, security for retirees, or universal coverage. We are supporting this plan because it contains all of the features we believe are critical for genuine reform. I hope the Congress will place itself squarely behind the President and commit to passage of this proposal.

Thank you, Mr. Chairman.

Mr. CLAY. Thank you. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman, members of the committee. My name is William R. Brown, Jr., and I am the president of the 83,000 member National Rural Letter Carriers' Association. I have a brief statement and ask that my full statement be included for the record.

I commend this committee for holding hearings on National Health Care Reform. This Congress has no more important issue on its agenda. Health care inflation will rapidly outstrip the rate of general inflation for the rest of the economy. By the year 2000, the rate of inflation for health care expenditures will be between 12 and 14 percent.

This rapid inflation, in only one sector of the economy, threatens to erase any deficit reduction and sustained economic recovery. This national trend leads our union to firmly believe that this country is faced with a major crisis in the area of health care costs.

I am pleased to give our views on H.R. 3600, the Health Security Act of 1993. The National Rural Letter Carriers' Association is a strong supporter of the Federal Employment Health Benefits Program, and has sponsored a health plan in the program since its inception. We believe that the White House task force used FEHBP as a model for their reform proposal and adopted many principles that have been part of the program for many years. That's probably why we favor much of the President's plan.

We support universal coverage unconditionally. This is an area where the Federal program has some faults. The FEHBP does not cover part-time workers. The Clinton plan corrects this inequity. Our part-time members deserve health coverage provided to them by their employers.

We strongly support a comprehensive benefit package. This principle exists in the current Federal program and in the President's proposal. A national plan should have it.

Choice is important and has been a part of the Federal program since its beginning. However, too many Federal plans are open to all employees and collect fees from nonmembers. We believe this practice must end.

If a Federal alliance emerges in compromise legislation, we believe that each Government employee should have the following choices: one Government-wide fee-for-service, one Government-wide preferred provider organization, and a choice of several HMO's.

The Office of Personnel Management operated the Federal program successfully for years. Some improvement would help a Federal alliance. Currently, OPM does not have the power of risk adjustment. Under the Clinton plan, risk adjustment would be available as a tool for all alliances.

The White House Task Force recognized that postal employees are unique Federal workers because we have the right to bargain collectively. The Health Security Act provides for the Postal Service

to have a corporate alliance. We would welcome a postal alliance and hope to offer our health plan under it.

We suspect that as Congress debates and discusses H.R. 3600, that changes and compromises will occur. It is our guess that in this debate that the FEHBP will be considered a Federal alliance. But if it is to be successful for the next 30 years, as it has for the last 30 years, it must be reformed.

We urge the committee to adopt the following principles from President Clinton's proposal regardless of the final shape of the legislation: Mandate universal coverage for all workers, both full- and part-time; demand a comprehensive benefit package; restrict enrollment in employee organization plans to actual members; make available to retirees a specific Medicare supplemental; empower all alliances with the duty of risk adjustment, and ensure a substantial employer contribution to worker's health premiums.

We thank the committee for your interest as always in the FEHBP. We hope that you will consider our views as you begin to seriously work on health care reform.

Mr. Chairman and members of the committee, that concludes your testimony, and I'd be pleased to answer any questions you might have. Thank you.

[The prepared statement of Mr. Brown, Jr., follows:]

PREPARED STATEMENT OF WILLIAM BROWN, JR., PRESIDENT, NATIONAL RURAL LETTER CARRIERS ASSOCIATION

Mr. Chairman and members of the Committee, my name is William R. Brown Jr. and I am the President of the 83,000 member National Rural Letter Carriers' Association. Rural letter carriers drive 2.8 Million miles daily to deliver mail on 48,000 rural routes to more than 21 million rural American families.

I commend this Committee for holding hearings on National Health Care Reform, especially as it relates to the Federal Employees Health Benefits Program (FEHBP). This Congress has no more important issue on its agenda. Reform of our current system will improve the quality of life that all Americans and their children will enjoy for many years into the future.

Currently, we spend $1.00 in $7.00 of our Gross Domestic Product on health care in this country, substantially more than any other developed nation. The rate of inflation of health care expenditures during the past decade has averaged over 10 percent, while the overall rate of inflation for the rest of the economy has been at 4 percent or less. And, while health care inflation has decreased to between 6 and 7 percent for 1993, we believe that is just temporary. Health care inflation will rapidly out-strip the rate of general inflation for the rest of the economy. Economists have estimated that by the year 2000 the rate of inflation for health care expenditures will again be between 12 and 14 percent.

This rapid inflation, in only one sector of the economy, threatens to erase any deficit reduction which this Congress and future ones would pass. It also threatens our slow, but sustained economic recovery and our ability to complete in the global economy.

Our union will be going to the bargaining table with the U.S. Postal Service in the near future. Rapidly increasing health care costs endanger our ability to bargain for any meaningful wage increases and threaten the level of the employer contribution for health care premiums. We need look no further than the recent arbitration decision imposed on postal clerks and city letter carriers. The arbitrator imposed a 4 percent reduction in the employers contribution toward health insurance premiums over the next 4 years for those two unions. So, the portion of the total cost that postal clerks and city letter carriers pay for health benefit coverage will increase. The national trend of rising health care costs puts pressure on employer-labor costs, and leads our union to firmly believe that this country is faced with a major crisis in the area of health care costs.

When President Clinton assumed office he asked the First Lady to chair his Health Care Reform Task Force. The product of that task force's efforts is H.R. 3600, The Health Security Act of 1993. Much has already been written and spoken

for and against this proposal and I would like to present you with our views on the legislation as it relates to our retirees and rural letter carriers.

The NRLCA is a strong supporter of the Federal Employees Health Benefit Program and has sponsored a health plan in the program since its inception. We believe that the White House Task Force used FEHBP as a model for their reform proposal and adopted many principles that have been part of the program for many years. That's probably why we favor much of the President's plan.

The Federal program has always had a policy of not excluding people for pre-existing conditions. Neither will it allow the health insurance coverage of someone with a medical problem to be dropped or for premiums to be increased on that family. It is employer based and requires a substantial employer contribution. We strongly support these principles.

The Federal program has some faults. For example, the FEHBP does not cover part-time workers. The Clinton plan corrects this inequity and requires that everyone working more than ten hours a pay period be enrolled in health coverage. For part-time workers, who work between 10 and 30 hours a pay period, the employer would make a pro-rata contribution, with a government subsidy. We strongly support health coverage for all workers—full or part-time. We have a large number of part-time workers in our craft. They deserve health care coverage provided to them through their employer, the same as full-time letter carriers.

We strongly support a comprehensive benefit package. This principle exists in the current federal program and in the president's proposal. The comprehensive benefit package laid out in H.R. 3600 is comparable to the benefits provided by the Rural Carrier Health Plan. We believe our plan provides excellent health insurance, and we believe that a national plan should, too.

Choice is important and has been a part of the Federal program since its beginning. In this area the current Federal program is a model, but a model that has gone awry. Too many plans are open to all employees. Some FEHBP plans are allowed to collect a fee from every individual who enrolls, but is not a member of the organization. We believe this practice must end. If a Federal alliance emerges in compromise legislation, we believe that each government employee should have the following choices: one government-wide fee-for-service plan, one government-wide preferred provider organization, the option of joining the health plan provided by their employee organization, and the choice of several HMOs.

The Federal program has operated for thirty years as an alliance without major change. It has worked so well that it would be hard to deny that it was used as a model by the White House Task Force. We support the alliance concept, which pools employees to achieve negotiating and purchasing power with health care providers. Despite the critics' charges that health alliances would be a bureaucratic nightmare, the Office of Personnel Management has successfully operated the Federal program with just over 100 employees. This is hardly a bureaucratic nightmare when you are talking about administering a health care plan for over 10 million members.

There are some improvements proposed in H.R. 3600 that we feel would enhance a Federal alliance. Currently OPM does not have the power of risk adjustment. Under the Clinton plan, risk adjustment would be available as a tool for all alliances.

Rural carrier retirees would have a Medicare supplement available to them for the first time through the federal government. This supplement would be designed specifically to compliment Medicare.

Postal employees are unique among federal workers because we have the right of collective bargaining for wages and benefits. The White House Task Force recognized the unique circumstance in providing for the U.S. Postal Service to have a corporate alliance. We would welcome a postal alliance.

We are strong supporters of the FEHBP, which has served as a working model and proved to be an effective alliance. We suspect that as Congress debates and discusses H.R. 3600 that changes and compromises will occur. It is our hope that in this debate that the FEHBP will be considered a federal alliance. But if it is to be successful for the next thirty years, as it has been for the last 30 years, it must be reformed.

We urge the Committee to adopt the following principles from President Clinton's proposal regardless of the final shape of the legislation: Mandate universal coverage for all workers—both full and part-time; demand a comprehensive benefit package; restrict enrollment in employee organization plans to actual numbers; make available to retirees a specific Medicare supplemental; empower all alliances with the duty of risk adjustment; ensure a substantial employer contribution to worker's health premiums.

We thank the Committee for your interest as always in the Federal Employees Health Benefits Program. It is our concern for our members and the right that you have given us to bargain collectively that has given many rural letter carriers an excellent quality of life. We thank our many friends on the committee for your concern once again and we hope that you will consider our views as you begin to seriously work on health care reform.

Mr. Chairman and members of the committee that concludes my testimony. I would be pleased to answer any questions you might have. Thank you.

Mr. CLAY. Thank you. Mr. Gardner.

Mr. GARDNER. Good morning. My name is Mark A. Gardner, and I am the national secretary-treasurer of the National Postal Mail Handlers Union.

Chairman Clay, I thank you and the other committee members for this opportunity to present the national Postal Mail Handlers' views on H.R. 3600, the Health Security Act. We have submitted a rather lengthy written testimony, that of Mail Handlers Union National President, William Quinn. With your permission, I will summarize that written testimony for you and the other committee members.

Mr. Chairman, our Union actively shares President Clinton's vision of a health care system that efficiently provides quality coverage for all Americans. In fact, I would like to take this opportunity to commend the President and First Lady for their untiring resolve to create a health insurance system that will provide quality, affordable health care coverage for all Americans.

In partnership with the CNA Insurance Companies, the Mail Handlers Union currently sponsors an FEHB plan that provides comprehensive, low-cost, fee-for-service benefit coverage to over 500,000 postal and Federal employees and annuitants nationwide. We are particularly proud of our success in extending our valuable coverage to the sometimes forgotten employees at the lower end of the wage scale.

The administration, Congress, and our union all agree that the FEHB Program has proven its ability to supply quality health care to postal and Federal employees and annuitants at a reasonable cost. Our own plan is a leader in those efforts to control FEHB Program benefit and premium costs. In fact, the FEHB Plan coverage already incorporates key elements of the President's reform proposal, such as guaranteed coverage regardless of health status, annual choice of coverage level, and the absence of preexisting condition limitations. What's more, MHBP coverage surpasses even the administration's proposed fee-for-service plan benefits in many key areas, thanks to our plan's development of a managed care infrastructure throughout the United States, an infrastructure in which we invested millions of dollars with the Federal Government's encouragement.

We have worked hard to build and maintain a quality, cost-conscious health plan that hundreds of thousands of postal and Federal employees freely choose each year during the open season. Having done so, we are greatly concerned about proposals to abolish the FEHB Program, including the Mail Handlers Benefit Plan and the vast managed care infrastructure that we have developed. We feel entitled, on behalf of our members, to insist on proof that any proposal to replace the FEHB Program with a new system

would treat postal and Federal employees as well as under the FEHB Program.

OPM's response to our concerns is that Federal and postal employees will fare well under the Health Security Act because the act would increase the Government contribution and would offer employees and annuitants the opportunity to enroll in new supplemental plans which would make them whole for the loss of FEHB Plan coverage. In our view, some of the assumptions on the part of OPM are not well-founded.

If the Health Security Act were enacted as proposed, an average Federal or postal employee would need to enroll in a regional alliance plan, a supplemental health benefits policy—which would replace, for example, FEHBP dental coverage—and a cost sharing policy—to reimburse additional out-of-pocket expenses—simply to duplicate the level of coverage that he or she previously had enjoyed under one FEHB plan. Each one of these coverages would impose a separate premium obligation on the employee. This triple premium payment necessarily would exceed the current employee contribution for Mail Handlers Benefit Plan or Blue Cross Standard Option coverage, among others.

Of course, I am aware that the Health Security Act offers the Postal Service the opportunity to establish a corporate alliance. However, I am pessimistic about the Postal Service's ability and/or desire to undertake the substantial effort involved in establishing and administering a corporate alliance. I also am aware that the Health Security Act discourages the establishment of any corporate alliances. Furthermore, we do not want to desert the Federal employees who currently enjoy Mail Handlers Benefit Plan and FEHBA coverage. In our view, Federal and postal employees and annuitants are better off sticking with a proven product, the FEHB Program.

Thus, our analysis inescapably leads to the conclusion that the FEHB Program must be preserved, but we believe that the program can be preserved within the administration's framework by coordinating FEHB Plan and regional alliance coverages in order to achieve universal coverage of postal and Federal employees. I can assure you that, given the opportunity, our plan will continue its leadership role in providing quality health care coverage to Federal and postal employees at all pay levels.

In his State of the Union address, the President stated that he is open to modifications in the Health Security Act that serve the worthy purposes of that proposal. We very much wish to work with the administration and with this committee to preserve the FEHB Program within the framework of the President's proposal.

Whatever happens, the FEHB Program must remain intact at least until the regional health alliances are established. In no event should the FEHB Program terminate before December 31 of the year in which all the regional alliances have become fully operational and have been proven effective.

Mr. Chairman, we thank you again for holding these hearings and allowing me to present the Mail Handlers Union's views on H.R. 3600.

[The prepared statement of Mr. Quinn follows:]

PREPARED STATEMENT OF WILLIAM H. QUINN, PRESIDENT, MAILHANDLERS' UNION, LIUNA, AFL–CIO

Chairman Clay, I thank you and the other Committee members for this opportunity to present the National Postal Mail Handlers Union's views on H.R. 3600, the Health Security Act. The Mail Handlers Union is the collective bargaining representative for over 50,000 postal workers. Our Union actively shares President Clinton's vision of a health care system that efficiently provides quality coverage for all Americans. In partnership with the CNA Insurance Companies ("CNA"), we currently sponsor a Federal Employees Health Benefits ("FEHB") plan that provides comprehensive, low cost, fee-for-service benefit coverage to over 500,000 postal and federal employees and annuitants nationwide. We are proud of the fact that our Mail Handlers Benefit Plan ("MHBP" or "Plan") has grown over the last 30 years to become the second largest plan in the FEHB Program and one of the largest group health plans in the country.

Our Plan is a recognized FEHB Program benefit and premium cost containment leader. In the mid-1980's, the MHBP was one of the first fee-for-service plans to institute hospital utilization review, catastrophic case management, and preferred provider organization ("PPO") programs. The success of these efforts over the past decade has permitted the Plan to add important new benefits such as prescription drug coverage and preventive care and to significantly enhance all of its benefit coverages. Throughout this time period, the MHBP has remained the lowest cost fee-for-service FEHB Plan. We take pride in the fact that our low rates permit the sometimes forgotten employees at the lower end of the wage scale to enjoy valuable MHBP coverage. Moreover, the entry of our low cost Plan into the "Big Six" Government contribution formula over ten years ago has saved the taxpayers millions of dollars in reduced Government contributions.

The Administration, Congress, and our Union are in agreement that the FEHB Program has proven its ability to supply quality health care to federal and postal employees and annuitants at a reasonable cost. In a September 14, 1993, press release, OPM announced a 3% increase in the overall cost of FEHB Program premiums in 1994. That is roughly equal to the current general inflation rate and is substantially below the health care services inflation rate. OPM also indicated that in 1994 40% of enrollees will see premium decreases and that a large number will have increased coverage for preventive care. Thanks to the success of various Congressional, OPM, and carrier initiatives, FEHB Plan premium increases have been significantly lower than those in the private sector, at least, over the past five years. Moreover, FEHB Plan coverage already incorporates the key elements of the President's proposal such as guaranteed coverage regardless of health status, annual choice of coverage level, and the absence of pre-existing condition limitations.

I therefore remain astonished by the fact that the FEHB Program is the only federal health program that the Health Security Act would disband. CHAMPUS and the Department of Veterans Affairs, among others, would be allowed the discretion to decide whether, and on what basis, to merge their programs with the regional alliances. Ironically, however, the FEHB Program is the only federal health program that successfully has controlled its benefit costs without extensive government-imposed price controls like DRGs that shift those costs to the private sector. In fact, the current CHAMPUS reform initiative seeks to model CHAMPUS upon the FEHB Program.

Why has the Administration singled out the FEHB Program for this adverse treatment? The Administration's spokespersons have stated quite bluntly that political concerns motivated this decision. HHS Assistant Secretary Judith Feder explained to the Committee on November 8, 1993, that transferring federal employees and annuitants to the regional alliance system would eliminate the public perception that federal workers receive better compensation and benefits than other Americans.

We believe that federal employee health benefits should not be treated like a political football. If federal employees are better off, than let's bring the rest of America into the FEHB Program. Isn't it better public policy to build on a successful model than to tear it down? We think so. Therefore, it should come as no surprise to this Committee that we oppose the abolition of our Plan and the rest of the FEHB Program.

Our Union's principal concern, of course, is the welfare of our membership. We therefore have scrutinized the OPM Director King's statement before this Committee last November that "FEHBP enrollees will fare well under the Health Security Act." Our conclusion is that this statement is inaccurate. The Administration concedes that the Health Security Act's core benefit packages are less generous than

FEHB Plan coverage by authorizing OPM to establish supplemental plans that "reflect the overall level of benefits generally afforded under FEHBP (as last in effect)" (§ 8203(f)(1)(B)).

Sixty five percent of FEHB Plan participants currently are enrolled in free-for-service plans. If these workers elected coverage under the Administration's "higher cost sharing" or fee-for-service option, they would be liable for 20% of all covered charges, including inpatient hospital charges, up to an individual out-of-pocket limit of $1,500 and a family limit of $3,000. That is a $1,000 copayment on a $5,000 hospital bill.

In contrast, the MHBP's popular High Option covers 100% of inpatient hospital bills after a $125 deductible that is waived if the patient utilizes a PPO hospital. The Blue Cross Government-wide plan and several smaller fee-for-service plans offer the same level of hospital coverage. All other FEHB fee-for-service plans currently cover 100% of room and board charges and impose a 5% to 20% copayment on ancillary hospital charges which is reduced or waived if the patient is admitted to a PPO hospital. This means that all FEHB Plan enrollees will suffer a serious hospital benefit cutback should their coverage be shifted to the regional alliances.

MHBP coverage surpasses the Administration's fee-for-service plan benefits in most key areas because our Plan has invested millions of dollars to develop Hospital and Physician/Laboratory PPOs throughout the United States. The MHBP now offers PPO coverage to over 65% of its enrollment. We place PPO's not only in large metropolitan areas such as Washington, D.C., but also in rural areas such as Anniston, Alabama, and Warner Robbins, Georgia. If an MHBP enrollee chooses to utilize a PPO doctor for surgical, maternity, or other medical services, the PPO doctor will submit the claim directly to the Plan which will cover 95% of the PPO negotiated rate. The enrollee has *no* paperwork and is liable only for 5% coinsurance. Moreover, even that small coinsurance factor disappears should the enrollee incur $2,000 in eligible out-of-pocket expenses for himself and his family. The Administration's proposal does not match our coverage. MHBP enrollees will see reduced benefit coverage from the Health Security Act.

Let me add here that, in 1990, Congress and OPM required all FEHB fee-for-service plans to implement benefit cost containment measures. Following that directive, the MHBP and the 11 other fee-for-service FEHB Plans have invested hundreds of millions of dollars in Government and employee contributions to create a successful nationwide infrastructure of PPO's and other cost containment mechanisms, such as mandatory hospital utilization review and catastrophic case management programs. These networks now cover urban and rural areas with high concentrations of federal employees in nearly all 50 states and the District of Columbia.

FEHB Plans have encouraged their members to use participating PPO hospitals and physicians through financial incentives, such as decreased or waived patient deductibles and/or coinsurance. As a result, FEHB Plan enrollees now have developed strong relationships with doctors in these managed care networks. OPM Director King recently credited this "managed care" infrastructure for the FEHB Program's success in controlling premiums. CNA estimates that the MHBP's hospital utilization review, catastrophic case management, and PPO programs will save the FEHB Program $77,000,000 in 1994.

The President's proposal to disband the FEHB Program would destroy this vast managed care infrastructure and would disrupt these cost effective FEHB Plan PPO participating doctor/patient relationships. Congresswoman Eleanor Holmes Norton has eloquently articulated the problems that dismantling the FEHB Program would create for the District of Columbia. We believe that the destruction of this managed care infrastructure would cause similar problems to arise in many other areas of the country with heavy concentrations of federal employees.

Moreover, the loss of the FEHB Program's managed care infrastructure would be far from the only FEHB Program improvement that the reform process would undo. Other lost investments include the following:

BENEFIT COST MANAGEMENT IMPROVEMENTS

At OPM's direction, FEHB Plans will provide OPM this March with a benefit claim utilization data tape that contains detailed information by patient in a standard format. FEHB Plans also are providing OPM with a standard format Demographic Data tape that contains detailed enrollment information on employees, annuitants, and dependents. This data will allow OPM to track utilization trends and patterns by Plan and across the entire FEHB Program.

CASH MANAGEMENT IMPROVEMENTS

Letter of Credit System—Since early 1989, FEHB fee-for-service plan carriers and underwriters have used a letter of credit to access Plan subscription income held in the U.S. Treasury. Initially, carriers and underwriters could draw down funds via the letter of credit upon issuance of a benefit or administrative expense check. Congress modified this scheme in the Omnibus Budget Reconciliation Act of 1990, 5 U.S.C. §8909(a). Thus, since early 1991, carriers and underwriters are not permitted to draw down funds from the Treasury until the benefit or administrative expense check is presented for payment at the Plan's bank. Consequently, carriers and underwriters now hold a minimal amount of working capital. (Of course, these entities further are required to segregate those FEHB Plan funds.) Thus FEHB Plan subscription income remains in the U.S. Treasury for the longest possible period of time. The Administration's reform proposal abandons this deficit cutting tool.

Premium Tax Preemption—Another provision of OBRA '90 exempted FEHB Plan carriers, underwriters, and administrators from the burden of state and municipal premium taxes effective January 1, 1991 (5 U.S.C. §8909(f)). The FEHB Program is thus treated like the Federal Employees Group Life Insurance Program which was exempted from premium tax levies in 1981. This measure saved the FEHB Program approximately $100 million in 1993.

Administrative Expense Reductions—FEHB fee-for-service plans and a small number of FEHB HMO plans are reimbursed for allowable administrative expenses up to an annual cap. Until December 31, 1987, that cap was based on a percentage of paid benefits. Effective January 1, 1988, OPM established the 1987 cap as a base and adjusted the base only for percentage changes in Plan enrollment and inflation (CPI–U) compared to the prior year. Effective January 1, 1993, OPM negotiated reductions in Plan administrative expense bases and eliminated automatic cap adjustments for enrollment changes. OPM would not possess such negotiating authority under the Health Security Act.

QUALITY ASSURANCE INITIATIVES

Correction of Deficiencies—Effective January 1, 1991, all FEHB Plans and underwriters must give OPM notice of "significant events" which may impact the Plan's ability to service Plan enrollees, such as disposal of material assets or labor disputes. In response to such notice, OPM is authorized to take one or more actions to protect Plan enrollees, including freezing enrollment and terminating the Plan. OPM further is authorized to take such actions without first receiving a Plan notice when it detects a material deficiency in the Plan's ability to administer its contract. OPM effectively would delegate this authority to the State governments under the Health Security Act.

Establishment of Plan Quality Assurance Programs—Effective January 1, 1991, all FEHB Plans must maintain a quality assurance program which at a minimum includes procedures to address: Accuracy and timeliness of claims adjudications; recovery of overpayments; quality of services and responsiveness to Plan enrollees and OPM; detection and recovery of fraudulent claims.

FEHB Plans are required to provide OPM with a copy of their quality assurance plan. OPM may order correction of deficiencies in such plans. Moreover, effective January 1, 1994, FEHB Plan must meet OPM specified quality assurance standards for claims adjudications, recovery of overpayments, claims audits, and timeliness of responding to written and telephonic inquiries.

Alternative Dispute Resolution—OPM continues to operate an effective FEHB disputed claim resolution procedure pursuant to 5 U.S.C. §8902(j) and 5 C.F.R. §890.105. This administrative program has reduced FEHB Plan benefit claim litigation.

Fraud and Abuse—At Congress' direction, FEHB Plans generally will not cover charges for services and supplies rendered by providers who are debarred or suspended from the Medicare program. OPM has expanded this rule to claims for services and supplies rendered by providers who have been debarred or suspended from any other federal program such as Medicaid or CHAMPUS.

OPM's Office of Inspector General has created a unit for investigating FEHB Program fraudulent claims activity and has established a fraud and abuse hotline.

ELECTRONIC CONNECTIVITY

Enrollment—Payroll offices provide enrollment information to FEHB Plans. CNA, on behalf of the MHBP, is working with the National Finance Center and the Department of Agriculture to automate the enrollment process. Five FEHB Plans including the MHBP are participating in the OPM sponsored Automated Reconciliation pilot project. This project seeks to simplify the process of reconciling payroll office and Plan office enrollment information. These projects—scheduled for implementation in 1994—will improve service to Plan enrollees and also will provide additional financial safeguards to the Plans and the Government.

Claims—With OPM's encouragement, FEHB Plans are increasing the number of benefit claims received electronically. For example, many FEHB Plans now are coordinating benefits with Medicare Part B carriers by computer tape. These changes improve time service to Plan enrollees and ultimately will reduce administrative costs.

We would encourage the Administration to adopt these reforms, not disregard them, and make them a part of the President's goal of increasing access to health care in urban and rural areas.

OPM customarily responds to these serious concerns by pointing out that the Health Security Act would reduce the employee's share of the health plan premium and that the new supplemental plans would make federal employees whole for their loss of FEHB Plan coverage. Our analysis is completely different.

The Government contribution under the Health Security Act would be 80% of the average regional alliance premium. The Administration estimates that the 1994 premium for enrolling in the Health Security Act's "higher cost sharing," or fee-for-service option, would be approximately $1,932 for self-only coverage, and $4,360 for two parent-and-family coverage. These rates would vary by region, and some health care actuaries are suggesting that these figures are low. While we will not find out the truth until the alliances are up and running, we do know right now that most FEHB Plan participants currently receive high quality medical coverage plus valuable dental coverage from one FEHB Plan for roughly the same rates—without having to purchase expensive supplemental coverage.

The 1994 premium for MHBP High Option coverage is $2,008 for an individual and $4,469 for a family. The current statutory formula sets the Government contribution at 60% of the Big Six average capped at 75% of the Plan's rate. The Government contribution for MHBP and Blue Cross Standard Option coverage currently is 75%—not 72%—of its total premium. Under this arrangement, the monthly federal employee contribution for 1994 MHBP High Option coverage is $41.84 for an individual and $93.10 for a family. If the Government contributed 80% of our Plan's premium, the employees' share would drop by $8.37 to $33.47 monthly for individual coverage and by $18.62 to $74.48 monthly for family coverage. That adds up to a premium reduction of $100 per year for an employee with self only coverage and $225 per year for an employee with family coverage. However, after federal and state income and Social Security/Medicare tax withholdings, the take-home pay increase would amount to only $6.25 per month/$75 per year for enrollees with self only coverage and $14.15 per month/$170 per year for enrollees with family coverage.

We reasonably can assume that the additional take-home pay created by the President's plan would be in the same ballpark. However, in return for such limited premium reductions, the federal worker must assume a new and substantial financial risk to retain the freedom of choice associated with a fee-for-service plan in the regional alliance—the 20% copayment obligation imposed on inpatient and outpatient care under the Administration's high cost sharing option. If a worker or her child is hospitalized even briefly, that copayment would quickly run up to $1,000 or more and would dwarf up any extra take home pay resulting from the increased Government contribution. Even without such a hospitalization, the federal worker would have to use the extra pay (and then some) to make up for the loss of valuable FEHB Plan dental coverage.

Moreover, unlike the FEHB Program, premiums for the same benefit package will vary by regional alliance depending upon demographic factors among other things. Regional alliances in certain geographic areas will charge above national average premiums, and the others will charge below national average premiums. This fact raises many questions. Will locality pay increases be eaten up by higher regional alliance premiums in urban areas? Will workers in rural areas with few health care resources need locality pay increases to cover high regional alliance premiums? We urge the Committee to require OPM to identify the winners and the losers as it pertains to the dissolution of our FEHB Program. Let's get all of the cards out on the table.

In our view, the supplemental plan proposal is a smokescreen. Members of this Committee justifiably have complained about the fact that the Health Security Act does not require OPM either to offer supplemental plans to employees and future annuitants or to make a Government contribution toward the premium if such plans are established. We simply find the whole concept hard to accept.

Consider this—under the Health Security Act, an average federal employee would need to enroll in a regional alliance plan, a supplemental health benefits policy (which would replace for example FEHB Plan dental coverage), and a cost sharing policy (to reimburse additional out-of-pocket expenses) to duplicate the same level of coverage that she previously had enjoyed under *one* FEHB Plan. Dividing current FEHB Plan coverage into two or three separately administered parts is contrary to the President's stated objective of "Simplicity." It will create administrative inefficiencies for the various plans, with the attendant extra costs, and confusion for the employees and annuitants. The triple premium payment for regional alliance, supplemental, and cost sharing coverage for any group necessarily will overshadow the employee contribution for coverage under the MHBP or the Blue Cross Standard Option.

Because these supplemental plans also will be prime targets for adverse selection, the people who most need supplemental coverage may find themselves priced out of the market. For example, let us consider the elderly non-Medicare eligible annuitants whom the Administration would place in a separate pool for supplemental coverage. Our underwriter, CNA, estimates that the average non-Medicare annuitant incurs twice the claims costs of an active employee. Under the FEHB Program, these senior citizens enjoy the same rates and benefits as all other federal employees and annuitants because of the existence of one risk pool for each plan or plan option. Obviously, this group would see its premiums skyrocket if it is left to fend for itself. Similar problems may beset the other supplemental plans and the mini-FEHB programs for overseas and temporary federal employees that OPM would establish and administer under the Administration's reform proposal. The supplemental plan approach will fail.

Maintaining the FEHB Program solves other problems. As this Committee is aware, the Health Security Act does not extend the employer 7.9% cap to governmental employers (§ 6123(a)(2)). The Government contribution to the FEHB Program is significantly less than 7.9% of the wage base. However, many employers which would be participating in the regional alliances with the Federal Government currently have a premium obligation that exceeds 7.9% of their respective wage bases. Consequently, the Health Security Act would expose the Federal Government to cost shifting from employers who enjoy the benefit of the premium cap. We expect that before long such cost shifting would cause the Government contribution to regional alliances to exceed 7.9% of the wage base. Undoubtedly, this premium cost spiral would put pressure on Congress to reduce other elements of the federal employee compensation package. Recent news reports indicate that State Governments such as New York and California now are joining the chorus of objections to this obvious inequity to governmental employers.

Thus our analysis inescapably leads to the conclusion that postal and federal employees and annuitants will not "fare well" under the Health Security Act. Mr. Chairman, national leaders such as Mrs. Clinton and yourself, among others, have hailed the FEHB Program and similarly effective state government employee health benefit programs such as CALPERS and the New York State employees health plan as good models for health care reform. These time-tested programs which have been built with public funds can and should be permitted to operate in the post-reform environment.

We believe that preservation of the FEHB Program is consistent with the structure of the reformed health care system as envisioned by the Health Security Act. The Act would allow large private sector employers with 5,000 or more employees to establish corporate alliances for their employees using existing plans. The FEHB Program, as the Nation's largest employer sponsored health plan, is the prototypical corporate alliance. In our view, the sensible approach is to incorporate the FEHB Program into the Administration's framework in a manner that achieves universal coverage of federal and postal employees and annuitants. I can assure you that given this opportunity our Plan will continue its leadership role in providing quality health care coverage to federal and postal employees at all pay levels.

Finally, we applaud the successful efforts of the Chairman and the Committee members to convince the White House to keep the FEHB Program intact at least until all regional alliances have been established. We agree with you and OPM Director King that the piecemeal dissolution of the FEHB Program contemplated by the Administration's initial reform proposal spelled serious trouble both for FEHB Plan enrollees and for OPM. I therefore remain concerned by the fact that the

Health Security Act would terminate the FEHB Program on December 31, 1997, regardless of whether the January 1, 1998, full implementation date has slipped. This provision is unnecessarily inflexible. If political forces dictate that the FEHB Program must be dissolved, then Congress must replace a proven product—the FEHB Program—with a proven product. Consequently, in no event should the FEHB Program terminate before December 31 of the year in which all the regional alliances have become fully operational and have been proven effective.

We have many other transition concerns that, with one exception, we will not address in detail at this time. I do wish to point out that in the event the FEHB Program is disbanded, over three million federal employees would be required to positively reenroll in the regional health alliances to which their coverage is transferred. In 1989, when Aetna withdrew from the FEHB Program, over 15% of its enrollees failed to positively reenroll in other FEHB Plans although OPM sent them four certified letters reminding them of their obligation to do so. If past experience is any guide, the positive reenrollment requirement of the President's reform proposal will cause many federal and postal employees and annuitants—particularly those elderly annuitants without Medicare coverage—to receive default coverage under the lowest cost plan in the regional alliance. Furthermore, Section 1323(i) of the Act would penalize such people by charging them twice the regular premium for the entire year unless they can show good cause for failing to make a timely election. Let's avoid this fiasco by preserving the FEHB Program.

Mr. Chairman, we thank you for holding these hearings and for allowing me to present the Mail Handlers Union's views on H.R. 3600. We believe the FEHB Program embodies the President's goals. We and our partners at CNA look forward to working with you and your colleagues on the Committee and the White House on the provisions of the Health Security Act that affect the federal and postal workforce.

Mr. CLAY. Thank you. Each of you has praised the FEHB Program and spoke of its successes over the 30 years of its existence.

Apart from the issue of whether or not a Postal Service corporate alliance is feasible or makes sense, there is a threshold issue: Should a program that's been working so well for over 30 years, has benefited millions and millions of people, and is now benefiting more than 9 million employees, retirees, and dependents, be dismantled even in the first place?

Mr. Biller, what is your feeling about that?

Mr. BILLER. Well, clearly, the administration is permitting a choice of a corporate alliance and collective bargaining. Again, like all legislation, nobody really knows the outcome.

If the FEHB Program is to be continued, then these flaws that have been described by each of the people here, I think, should be corrected. Presently, as I say, I'm interested in a collective bargaining process. I'm interested in a corporate alliance where, also, if that happens, I would not want our benefits or those of retirees to be reduced.

I'm equally concerned in the discontinuance of FEHB with retirees going into the regional alliances, again, to make sure that they don't get any less of a guarantee than they have now.

These are problems continually in new legislation, and we don't want to be timid souls but, at the same time, that we should know what we're getting rather than having it dismantled before we know what we're getting.

Mr. CLAY. Mr. Sombrotto.

Mr. SOMBROTTO. Well, if you're asking me to write the bill and Congress will vote for it and it will get enacted, I would say continue FEHBA.

Mr. CLAY. Well, this committee is going to write the bill.

Mr. SOMBROTTO. Well, I understand that, but the question assumes we can write it together. However, what I'm getting at is the

political reality. This is a political question. The members that we represent are used to FEHBA, have functioned under it, and benefited from it for over 30 years. It has its flaws. All of us have pointed out to some degree the flaws in FEHBA, and we understand them.

The question is, can FEHBP be isolated from overall, comprehensive, universal medical program under the Health Security Act? If I had my choice, I would say continue FEHBA, but I recognize that that might not be possible at the end of the day.

Actually, what the President is proposing is using FEHBA as almost a prototype. The very program of managed care is what we've been experiencing under FEHBA for the past 30 years.

Mr. CLAY. In your statement, you talked about the independence of the Postal Service and postal employees and that they ought to be treated like the private sector. Yet you said it would be unfair to impose the 1-percent assessment. How can you have it both ways?

Mr. SOMBROTTO. Well, the reason for that is there are others permitted to establish a corporate alliance, such as the Taft-Hartley Plans. They don't pay 1 percent—but, beyond that, the Postal Service has been paying each year a substantial amount of moneys into the coffers of the U.S. Government. We think that it would be unfair to once again tax the Postal Service and assess it an additional 1 percent.

Mr. CLAY. Mr. Brown, would you care to comment?

Mr. BROWN. Thank you, Mr. Chairman. We, the National Rural Letter Carriers, are happy with what we've got, the FEHB plan. We know it, just as Vince has stated. We know the program. The only thing that we see that's wrong with it, we have about 44,000 what we call relief employees, and they are not covered with any kind of health program. The only way they are covered is that they have to go outside the Postal Service to get it. And we see that as a big problem with FEHBP. And that would be the only change that we could see about it, but I think, like I say in my testimony, you could take some of the President's plan and reform FEHB and I think we would have a good plan. But on the outside, if we go outside and drop FEHBP, I'm like President Moe Biller, I wonder what kind of plan it would be and how it would work.

So, we're encouraging you, that you consider keeping the FEHB plan and do some reforming with it, and I think we would have a good plan.

Mr. CLAY. Thank you. Mr. Gardner.

Mr. GARDNER. Mr. Chairman, in our view, as we indicated both in our written and my oral testimony, we believe the FEHBA system and the program itself is a model health care system. We've built it up over many, many years of hard work and a lot of contributions both from the Federal Government's share of the contributions as well as from the carriers. We've allowed the premium increases to stay down this year to roughly the rate of inflation, 3 percent across-the-board. And, in fact, 40 percent of all the FEHBP enrollees had an actual decrease in their premiums this year.

Again, we think it's the model health plan. And if the question is, should we disband it? Absolutely not. The answer, in my view, is to put it in the framework of the Health Security Act.

Mr. CLAY. Thank you. Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. Gardner, I'd like to follow up on what you've just said in answer to the Chairman's questions. You say that 40 percent of those enrolled in your plan actually had a decrease in premium last year?

Mr. GARDNER. Yes, that's according to an OPM released statement, I believe, in September of last year, not just in our plan, but 40 percent of all FEHBA enrollees in the nationwide system had a decrease in their—40 percent had a decrease in their premiums this year.

Ms. NORTON. These are figures we'll have to look more closely at. FEHBA apparently had an 8-percent increase overall, which was more favorable than what the private sector was experiencing.

Mr. GARDNER. I heard one of my colleagues up here testifying that the average premium increase for the FEHBA system over prior years, I believe, was 8.4 percent, according to somebody. But this year alone, due to a lot of the reforms that have taken place in recent years, it's continuing to keep those premiums down at a manageable point.

Ms. NORTON. And so people are paying less.

Mr. GARDNER. Forty percent are paying less this year than they did last year.

Ms. NORTON. It's very important for us to figure out why. I mean, that could be because they are getting less. Health care costs so much that there are a number of options to you, and that is to take an option that costs you less.

Mr. GARDNER. I disagree. I mean, it's possible that that could be an option, but in a review of the various health plans from last year, you can see that actually many of the benefit programs had an increase in benefits. I mean, it's very clear. And I believe it's through the efforts of the Congress, of the carriers, of this committee, that have allowed OPM to put mandates out for cost containment measures that, in effect, make the plans work more administratively in a proper manner, as opposed to decreasing the benefits.

Ms. NORTON. Well, the figures you offer are very important for us to look behind because, as you indicate, FEHBA is a model. I didn't realize it was that much of a model. Mine went up, by the way. Mine did not go down. But that doesn't tell us much.

You all have rather detailed critiques of FEHBA, even though you want to keep it, and that is, of course, understandable. Some of those critiques—some of those problems, of course, would be cured simply by going from FEHBA to the President's plan, like the fact that my son, next year, is not going to be covered because he's going to be 22, or the failure to cover casuals and transitionals, or the 5-year rule, a terrible rule for retirees. I mean, all of that would be gone, and we wouldn't have to fiddle with FEHBA if we move to the new alliance program. So, why isn't that better than trying to go through the painful process the committee has attempted over the past few years, of reforming FEHBA?

Mr. GARDNER. If I might, in viewing the testimony that we've given you today, it would be our suggestion and recommendation to develop a system, an amendment to the Health Security Act, that would allow FEHBA to work along side or concurrently with

the health alliances. So, in your case, the example of somebody who reaches that age where a dependant is no longer covered, they would leave the FEHBA system and enter into a regional alliance. Let's let them work together, continue to build the FEHBA system, and continue to model the health alliances on that system.

Ms. NORTON. Does anyone else have a response to that?

Mr. SOMBROTTO. Well, one of the attractions, obviously, is the Health Security Act, the fact that it has universal coverage. And as I pointed out in my testimony, in my own union, we have about 28,000 transitional employees that are not covered by health benefits, and upwards of 3,000 casuals that are also not covered by health insurance. We think that's an abomination. We've struggled mightily to try to influence the Postal Service to cover those employees, during the 1994 contract negotiations. However, we were unsuccessful. However, we may not have a choice here but, if the choice is to continue FEHBA as it is, without having those benefits provided for those folks that are not covered, then we couldn't support it.

We have to have universal coverage and, if we can do that within the framework of FEHBA, that's fine.

Ms. NORTON. Incidentally, are Mr. Sombrotto and Mr. Gardner talking about the same plan because, Mr. Sombrotto, you testified that the President's plan offered benefits at least as favorable, in some instances more generous, and Mr. Gardner indicates the need for supplemental benefits and reimbursements for out-of-pocket expenses if one goes into the alliances. Are these the same plans, or different plans?

Mr. SOMBROTTO. Well, our analysis showed that when you put them side-by-side, as Brother Biller has pointed out in his testimony and when you compare it with Blue Cross-Blue Shield, or you compare it with our plan, there are a lot of differences in benefits. Some are taken away, some are given. But, on balance, the core package of the Health Security Act is as good as, or better than the average plan in FEHBA—in fact, the major plan of FEHBA, which is Blue Cross-Blue Shield is inferior to the President's plan.

Mr. BILLER. One of the problems, I think, of concern, and I guess that concerns most Americans anyway, but particularly in the FEHBA Program, is the administration's own presentation and what appears to be a slippage, and that's been pointed out. And that's of great concern because you don't know what the ultimate product will be. It's great to come out and support something, and you come out with much less than you had, and people say, "What did you do? You don't know what you did."

The concerns expressed, as a matter of fact, in terms of the President's comments just the other day that, well, he'll take kind of anything, as long as it's universal. These are laudable goals, but if they don't apply to us, we have problems.

Ms. NORTON. Mr. Gardner?

Mr. GARDNER. In the comparison of the core benefit package, to look at them at first blush, you might—or one might suggest that they are comparable but, if you bear in mind that roughly 65 percent of the FEHBA plan participants are currently enrolled in fee-for-service plans or, as the Health Security Act describes, the

"higher cost-sharing plan," those folks would have a 20 percent copayment on hospitalization charges.

And one example that would really show the difference between those two plans, the core benefit packages of both FEHBA and the Health Security Act, would be a single $5,000 hospital bill wherein, at 20 percent, the enrollee would pay a $1,000 copayment, compared to the managed care, the infrastructure that the FEHBA system has developed, where it could be the entire amount could be waived, including the deductible if you are in one of the PPO provider hospitals. There are serious differences between the core benefit package offered in the Health Security Act and what's available in FEHBA today.

Ms. NORTON. Of course, in the alliances, you can choose apparently whether to go into a fee-for-service or an HMO.

Mr. GARDNER. But you would have one fee-for-service, as I understand it, in each alliance. In my view, one of the beauties of the FEHBA system is the fact that if you don't like one, you have 10 others, and you vote with your feet each year.

Ms. NORTON. If one listens to the testimony of all of you, there is, I think, appropriate fear of the unknown. You know what you've got now, you don't know what you'd get. The notion that the chairman voiced early on, of waiting, for example, until the alliances would be fully in place before anybody would have to transfer out of FEHBA. Would that begin to deal with concerns that you have, because then at least you'd know what you would be getting because it would be on the ground?

Mr. GARDNER. I, for one, would hate to see a piecemeal dissolution of FEHBA. If it's got to go, I would rather see it go in one fell swoop, after they are up and running and proving effective.

Ms. NORTON. But I'm asking, inasmuch as the committee is disinclined for all kinds of reasons, to dismember FEHBA piece-by-piece, it may well be that you'd be in a better position to judge after the alliance is well in place and then FEHBA moved out, at that point, if that became appropriate.

Mr. GARDNER. But what we're asked to consider under the Health Security Act is language that would, in effect, dismantle it. I mean, there would be no choice once the Health Security Act was passed. As of December 31, 1997, it would be history.

Ms. NORTON. Of course, the Health Security Act is here for whatever changes this committee chooses to make.

Final question, Mr. Chairman. I'd like some example, some notion, perhaps by way of example, of how collective bargaining would be affected by the President's plan. I mean, would you be bargaining in about the same way you do now? What differences, if any, do you expect that the President's plan would generate to the collective bargaining process?

Mr. SOMBROTTO. Well, we could still bargain collectively. I notice that there are members of management here. Maybe they could be much more gentle at bargaining, and they could pay for 100 percent of all the coverage for postal employees. I hope they are listening. But, no, I think there would still be opportunities for us to bargain collectively with the employer, notwithstanding the fact that the Health Security Act would be passed. But, again, all this is conditioned on what the final product is going to be.

This is like playing baseball at night without any lights. We don't know what is going to be the final product. I think that—and maybe I'm just offering this gratuitously, and I apologize to my colleagues here—but I think we all have the same view that we're supporting universal coverage. We want to protect our members because they have certain benefits now, and we don't want to see those benefits eroded. If the President's plan, as it's now proposed, is passed—if you could do that by magic—that would be fine. However, our concerns are that there may be a lot of changes along the way that may then influence us to go in another direction, and may lead us to the conclusion that we may not support it.

So, it's difficult for us to make judgments here. We do know that we functioned under FEHBA for 30 years. We do know that it has its flaws, and we've tried to correct them, all of us have, over the years. With the cooperation of the Congress we've made some improvements, and we thank them for that.

Mr. CLAY. The time of the gentlelady has expired.

Mrs. Morella.

Mrs. MORELLA. Thank you, Mr. Chairman. I'd like to ask unanimous consent for a statement to be included in the record, dealing with this hearing. Thanks for establishing it.

Mr. CLAY. Without objection, so ordered.

[The prepared statement of Hon. Constance A. Morella follows:]

PREPARED STATEMENT OF HON. CONSTANCE A. MORELLA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, thank you for the opportunity to welcome our witnesses and to say a few words regarding health care and the Federal Employee Health Benefits Program (FEHBP).

You have assembled a group of postal service luminaries, and indeed, when they speak this committee listens. The association representatives take very seriously their constituent concerns and I recognize their dedication.

The discussion today will center around the issues of continuing FEHBP for federal employees and retirees, the latitude given to the USPS to create its own health care alliance as a corporate entity, and the development of a system for federal and postal employees and retirees which will retain the same level of benefits as they have received for almost 35 years.

In reading some of the testimony, I find it fascinating that whereas the Postal Service is being considered a corporate entity because it has more than 5,000 employees (it employs over 700,000 workers), it may administer its own program. However, the Postal Service does not, at this time, want to create its own alliance because it does not have the experience nor the claims utilization data to develop the program. On the other hand, federal employees and retirees are clamoring to retain FEHBP (because, in spite of its flaws, it is a known entity and—thanks to the Office of Personnel Management—perhaps the best managed system in the country), the Administration seeks to dismantle it because of the perception that federal employees and retirees are getting better benefits than the general public. At the same time, the Administration proposes to leave the veterans administration health care system—which is widely perceived as being inadequate and in need of reform—wholly intact. Isn't this ironic? The President should provide justification for this disparate treatment for separate but comparable sectors of federal service.

There is no doubt in my mind that every American must be covered by adequate and affordable health care. We simply must be careful before we start disassembling proven programs that have been in existence over several decades.

Thank you, Mr. Chairman.

Mrs. MORELLA. It's nice to see luminaries here, who always give us good advice and counsel but, as I was sitting here listening to the testimony, it appeared to me that I heard that three of the four of you said in your statements, that you approved of the President's Health Care Reform Act. It wasn't until the chairman asked the

specific question, which do you prefer, that you said, well, we like the FEHBP; it is working well, we like it. And then I heard another statement.

Mr. Sombrotto, you said that you did want universal coverage. That was something that FEHBA doesn't offer. Very succinctly, in the statement of the Mail Handlers Union, Mr. Gardner comments on the fact that consistently he thinks FEHBA should stay.

I noticed that in the statement before us, an astonishing statement made, as it is called here, that "FEHBA would be the only Federal health program that the Health Security Act would disband. CHAMPUS, Department of Veterans Affairs, among others—and we know the Postal Service, too—would be allowed the discretion to decide whether, and on what basis, to merge their programs with the regional alliances. Ironically, the FEHB Program is the only Federal health program that successfully has controlled its benefit costs, without extensive Government-imposed price controls like DRG's that shift those costs to the private sector. In fact, the current CHAMPUS reform initiative seeks to model CHAMPUS upon the FEHB Program."

Given all of that, I am curious about why you vacillate on it. If you feel that FEHBA should be its own alliance, with 9.1 million people who are enrolled, then why don't you say that first, and then say that if that doesn't happen, then you want certain things to come about. Is that the way you do feel? I know how you feel, Mr. Gardner. Would the rest of you like to comment on that?

I just want you to know, for instance, I'm hearing from a lot of retirees, who are very much against disbanding the FEHB Program, and I'm just curious about how you strongly feel. Do you strongly feel that FEHBA should stay, but then if it can't, you'll go another way? Just to clarify in my mind.

And, incidentally, Mr. Biller, glad that you're doing so well.

Mr. BILLER. Thank you. Well, again, I think we've stated our position here, and I don't think it's a matter of vacillating. We are concerned about what is in the offing. There are areas of major support for the President's program in terms of our collective bargaining process, again. As a matter of fact, what hasn't been mentioned here is that the arbitrator, in the last negotiations, decided that, at least us in the joint bargaining committee, would have to have a committee to meet before December 31, 1994, in terms of determining whether there is going to be a postal-only plan, which probably is the equivalent in the legislation which permits a corporate plan.

We also have great concerns as to where retirees will go, or where they will fare, within the regional alliances. At the same time, we don't want to take second money, you know. You say we know what we have. Nobody has given us the opportunity to see what we're going to get. If retirees or active employees are going to wind up better somewhere else, that's fine. You know the old story, you don't know what you've got and you don't know what you're getting. And then the way things are going, as I pointed out before, we hear different types of things almost every week in terms of the administration. The other day, the President said he'd be satisfied to make all sorts of accommodations. We cannot buy a-pig-in-a-poke.

So, it isn't a question of merely vacillating. It is a question of also attempting to collect, that what we have in the FEHBA Program, if that is what you're going to keep, but none of us know. You should all know that nobody can determine what comes out in the final process of the Congress of the United States, and we're dealing with one body here, and a different thing is going on in the Senate of the United States. So, it's not that simple.

Mrs. MORELLA. Because we always say, "If it ain't broke, don't fix it."

Mr. BILLER. Well, there are a few things that are broken, and we'd like to fix them. And as Vinnie pointed out, if the Postal Service, in its negotiations, see, fit to guarantee 100-percent coverage the way we are, we'll be glad to have that.

Mr. SOMBROTTO. Well, let me just add something because you make a good point, and maybe I didn't articulate our position that clearly.

What I'm saying is this. We support the President's Health Security Act under these conditions: That the Postal Service be allowed to have a corporate alliance; that the Postal Service does not pay a 1-percent premium for that privilege; and that all of the factors that we've talked about are contained in that bill.

That all changes if the core package changes. That all changes if the Postal Service is not allowed to be, or doesn't want to be, a corporate alliance. It's our responsibility to convince them it's in their best interest and our best interest. It's in our joint best interest. That all changes if retirees are not protected under the Health Security Act the way they are protected under FEHBA.

So, while we are supporting the broad principle of the Health Security Act, it is within the context which I've just stated it. Now, any one of those elements might fade away and then we'd have to revisit our support. If we came to that point, then we would say leave us where we are. We'd accept FEHBA the way it is because we know what we have and we can live with that. But we're not saying that we prefer FEHBA.

Mrs. MORELLA. Do you think Federal employees should have their own alliance?

Mr. SOMBROTTO. I think the Postal Service should have its own alliance.

Mrs. MORELLA. They will, but I mean the other Federal employees.

Mr. SOMBROTTO. Well, that's for them to decide. We have a different situation than other Federal employees, as you're well aware, and that's up to them. I mean, I don't know what they want to do or don't want to do. I can't speak for them, but I can speak for my union, and we want the Postal Service to have its own alliance. We do not want it to be taxed with that 1 percent, and we want to have all of the benefits that are in the Health Security Act.

Mr. BILLER. And we join with the NALC in that regard. If I may, I'd like to point out one other thing in terms of the FEHBA premiums. The Blue Cross High, because you have it in the "big six" and their premiums are much higher than the others, kind of artificially increases the premiums at that the Federal workers have to pay.

Mrs. MORELLA. Mr. Brown, do you want to comment on that?

Mr. BROWN. I appreciate what my colleagues have said over there. My people are saying, like you said, if it's not broken, don't fix it. But there are some changes that we know need to take place. Like I said in my testimony, we've got 44,000 relief employees out there that are not covered. And if they get it, they have to go outside somewhere to get it.

The retirees are satisfied with what they've got, and they are afraid to make a change because of the way the alliance may be set up. They are afraid they can't go to the doctors that they want to, and they are really disturbed over it. And I think we have a good plan in FEHBA, and I hope there's some way that the committee can see to keep it, but it's going to be reformed a little bit.

This is a world attraction, if you want to put it like that. And let me say something I think will make a lot of sense. I saw last weekend that they were having a baseball game on a ice-frozen field, and I think this committee, and we, are out there, and we hit the ball. We know the ball is going through the air, but we don't know where we're going to stop when we run. And I think that's just about the way we are, and you are in this committee. The ball is fixing to be hit, but we don't know what the results are going to be.

Mrs. MORELLA. Thank you. Mr. Gardner, do you want to make any comment?

Mr. GARDNER. The only comment I would like to make with regard to the Postal Service setting up and administering a corporate alliance, just the sheer numbers of having the Federal employees with millions of potential employees, has leverage to negotiate with PPO networks, et cetera, as opposed to 700,000 postal employees—I mean, the numbers are where you're going to get your savings.

Mrs. MORELLA. That's right. Thank you. Thank you, Mr. Chairman.

Mr. CLAY. Thank you. Mrs. Byrne.

Mrs. BYRNE. I have just one kind of question-comment. In talking to the people in my district, I think the Federal employees and postal employees included in this, their biggest concern is because of the number of people that are currently in the FEHBA system, it's going to be used to subsidize universal coverage. That's their biggest concern that they've expressed to me, that we're going to get less, we're going to probably pay the same or more, and that's so that the Federal Government can accomplish its goal of universal coverage, which I think we all share as a goal, that if it comes right down to it that the only way to get universal coverage is to include FEHBA in the Health Reform Plan, are you saying you are willing to do that?

Mr. SOMBROTTO. No. Are you saying that we have to take less, do I get that to be the meaning of your question?

Mrs. BYRNE. I'm saying that to accomplish the goal of universal coverage, are you willing, even if it means that you're not going to get all of the things you want in FEHBA, the choices, to say we'll forgive that. We won't go after the part-time employees. We won't go after the waiver for the 1-percent tax. We won't do any of those things, to accomplish the goal of universal coverage.

Mr. SOMBROTTO. Well, I think I made the position very clear. If there's an equilibrium between what we have and what we're going

to get, we accept that—call it the Health Security Act, call it whatever you want—but at the end of the day, if there is that equilibrium, then we support it. However, if it's not there, if you're asking us—and I want to get this on the record. I think it's important for everybody to understand this.

Ninety-five percent of the members of my union are covered by health benefits. They have it. They have comprehensive care for themselves and their families. If they wanted to be selfish, they'd say, "Look, we've got ours, we're not worried about universal coverage. Why should we have to worry about somebody that's working that doesn't have coverage?" We support universal coverage because it's the right thing to do.

In this society, with the most advanced democracy in the world, for us to have 37 million—25 million workers not covered, an additional 12,000 to 15,000 that don't have ample coverage—is an abomination.

So, our membership supports the idea of universal coverage. And we want to help accomplish that. And we think it can be done within the framework of what we've outlined here. But I don't think it would be fair to say that we should subsidize universal coverage. And I think that all of us have made that pretty clear here, that we would take a different position if the Health Security Act is watered down to the point that our membership would suffer.

Mrs. BYRNE. Thank you. Thank you, Mr. Chairman.

Mr. CLAY. Mr. Sombrotto, the taxpayers and ratepayers now subsidize the health insurance of Federal and postal employees to the tune of 75 percent. Why doesn't the Government have an obligation to subsidize the 37 to 38 million people who are not insured?

Mr. SOMBROTTO. Well, I feel the same way about that, Mr. Chairman. You have a friend here when you make that statement. I'm for universal coverage. I don't care how we do it, but we ought to do it. We shouldn't do it on the backs of some other people that can least afford to have it done on their backs.

Mr. CLAY. That's the statement I wanted you to put in the record. Thank you, Mr. Sombrotto.

Mr. SOMBROTTO. You worked it out of me pretty good.

Mr. BILLER. I want to make sure that we know that the Postal Service is not subsidized to the tune of 75 percent, it's a collectively bargained agreement.

Mr. CLAY. Who is paying the 75 percent? The users. The people who use the mail service pay it.

Mr. BILLER. That's correct.

Mr. CLAY. OK. You are being subsidized. The whole American system is subsidized in some kind of way. Some of them call it welfare, and the others call it subsidies, or anything they want. But we have an obligation to provide a minimum standard of living for all American citizens, and part of that is health care coverage. So, I don't care who pays for it, but it's got to be done. Thank you. Thank all of you for your testimony.

Ms. NORTON. Mr. Chairman, could I just say something for the record?

Mr. CLAY. Yes.

Ms. NORTON. I just want to indicate that the distinction that you've just made, and I think that Congresswoman Byrne was alluding to, the difference, Mr. Gardner, between you and Mr. Sombrotto, is emblematic. Mr. Sombrotto is saying, you know, there are a lot of uncovered workers, and some of them are in his own union, and he hasn't been able to get them covered, he knows he's not going to be able to get them covered even through the collective bargaining process.

As I read your testimony, you are saying, under the President's plan, our choices are limited. He's saying the level of benefits themselves are limited. Now, I think it's time for the President to let us know that in his plan, if we are going to cover all these uncovered people, precisely what is going to happen is that the choices will be limited.

Now, I must tell you, if the cost of getting millions of people who work every day covered, is that people like me have less of a choice. I'm in fee-for-service now, and I may be driven into HMO. I am hard-pressed to say that that is not the kind of tradeoff that the American trade union movement has stood for and that I have stood for all my life, and I think somebody's got to get out here and tell somebody—I don't think the President has—that there is no free lunch, and that somehow we are not going to get all these uncovered workers, especially those—84 percent—of the uncovered workers work every day, of the uncovered Americans who work every day—we're not going to get all of them covered and the rest of us have the same diversity of across-the-board choices that we had all along. I just want to say it on the record, Mr. Chairman.

Mr. CLAY. Unless we make a lot of people who are shirking their responsibilities as employers pay for health insurance then it will continue to have an adverse impact on us. We cannot let them continue to escape their responsibilities.

I want to thank the witnesses for very excellent testimony. Thank you.

The next panel will consist of Mr. David Games, president, National Association of Postmasters; Mr. Armando Olvera, president, National League of Postmasters; and Mr. Vincent Palladino, president, National Association of Postal Supervisors.

Gentlemen, welcome to the witness table. Without objection, all of your statements will be included in the record. We would appreciate it if you would summarize your remarks so that we could have more time to ask questions. The first witness is Mr. Games.

STATEMENTS OF DAVID GAMES, PRESIDENT, NATIONAL ASSOCIATION OF POSTMASTERS OF THE UNITED STATES, ACCOMPANIED BY ARMANDO OLVERA, PRESIDENT, NATIONAL LEAGUE OF POSTMASTERS, AND VINCENT PALLADINO, PRESIDENT, NATIONAL ASSOCIATION OF POSTAL SUPERVISORS

Mr. GAMES. Thank you, Chairman Clay. Good morning. I am David Games, President of the National Association of Postmasters, NAPUS, and I'm testifying on behalf of the 42,000 active and retired postmasters throughout the United States. With me is Teena Cregan, who is our new director of government relations, and she may be familiar to you. I have a very brief statement.

We are here to discuss the Clinton health plan, H.R. 3600, and its effects on the Federal Employee Health Benefit Plan, FEHBP. We thank the committee for giving us the opportunity to address this issue of concern to our members.

As you know, more than 90 million Federal and postal employees and retirees are covered by FEHBP. NAPUS administers one of the 300 FEHBP approved health plans, and ours is a closed plan serving only postmasters and retirees.

First, we particularly want to thank Chairman Clay for working to protect the current health care plan for Federal and postal employees through 1997. Mr. Chairman, you have stated that you have grave concerns about the abolishment of the Federal program. We share those concerns.

The Nation's postmasters and families have come to rely upon FEHBP for vital health care, and it is our responsibility to make sure that their rights and benefits are protected. We want to make sure that no matter what form the final legislation may take, our members are left no worse off than they are today.

NAPUS supports the concept of universal health care and universal access to affordable health care, and applauds President Clinton for taking on the task of developing such a plan. However, we believe that Federal and postal employees have special circumstances that should be considered under any plan Congress may adopt.

Under the administration's plan, employees who are now covered by FEHBP would be required to join a regional health alliance or a corporate alliance. The Postal Service has been offered the option of developing a corporate alliance, like those of large private businesses. We support that option if the Postal Service wants to take on that responsibility. However, H.R. 3600, as it is currently written provides many disincentives in development and operation of such a plan. We fear that unless the Postal Service is excused from some of the requirements, the costs for a corporate plan would be prohibitive.

If Federal and postal employees are covered through regional alliances instead, each alliance would, as we understand it, bargain for coverage of its own alliance-wide health care costs. States would have a great deal of latitude in developing their own programs, and the program costs will vary from alliance to alliance. Because the Postal Service has employees in virtually every town and city, it will have to deal with all the alliances to cover its employees. Since costs will vary among alliances, contributions for the employees' portion of the compensation will also vary.

Also, NAPUS represents many retirees. A number of members opt to retire at age 55 or 60 and are not eligible for Medicare. We want to ensure that their health benefits are not reduced or that their costs do not rise prohibitively when they leave the Postal Service.

The Government has already spent millions of dollars over the past 30 years setting up FEHBP and developing the facilities, the personnel, and the equipment needed to administer it. The timetable for enactment of health care and establishment of the regional alliances is likely to change, and we urge Congress to support legislation that would continue the FEHB Program at least

until there are good working alternatives. That will at least ensure that the Federal and postal employees will not lose their current coverage while the new health plan is being implemented.

It really is difficult to comment more specifically on the plan without knowing the dollar figures, but I would be happy to answer any questions you may have, and I thank you for your attention.

[The prepared statement of Mr. Games follows:]

PREPARED STATEMENT OF DAVID GAMES, PRESIDENT, NATIONAL ASSOCIATION OF POSTMASTERS OF THE UNITED STATES

Mr. Chairman, members of the Committee, I am David Games, President of the National Association of Postmasters of the United States (NAPUS). NAPUS has been in existence since 1989 and it represents 42,000 active and retired postmasters throughout the United States.

We are here to discuss the Clinton Health Plan [H.R. 3600] and its effects on the Federal Employee Health Benefit Plan (FEHBP). We thank you and the Committee for giving us the opportunity to address this issue of concern to our members.

As you know, more than 9 million federal and postal employees and retirees are covered by FEHBP. NAPUS administers one of the 300 FEHBP approved health plans. Ours is a closed plan serving postmasters and retirees.

First, we particularly want to thank Chairman Clay for working to protect the current health care plan for federal and postal employees through 1997. Mr. Chairman, you have stated that you have grave concerns about the abolishment of the federal program. We share those concerns. The nation's postmasters and families have come to rely upon FEHBP for vital health care needs and it is our responsibility to make sure their rights and benefits are protected. We want to make sure that, no matter what form the final legislation may take, our members are left no worse off than they are today.

Under the Clinton plan, FEHBP would close on December 31, 1997. Instead, federal and postal employees would purchase health insurance through regional alliances or through a corporate alliance. In testimony before this Committee on Nov. 9, 1993, Director James King of the Office of Personnel Management said that "The FEHBP operates much like the regional health alliances the president is proposing, so federal employees should not experience a significant change when they move into the new system." However, we see some problems and believe that such a transition is going to be more difficult than the administration has envisioned.

Now we want to be very clear. NAPUS supports the concept of universal access to affordable healthcare and applauds President Clinton for taking on the task of developing such a plan. We do not wish to be mere naysayers. Instead we would like to be team players with the administration and Congress in developing a system of coverage which would benefit all Americans. However, we believe that federal and postal employees have special circumstances that should be considered under any plan Congress may adopt.

Under the administration's plan, employees who are now covered by FEHBP would be required to join a regional health alliance or a corporate alliance. The Postal Service has been offered the option of developing a corporate alliance, like those of large private businesses. We support that option if the Postal Service wants to take on that responsibility.

However, H.R. 3600, as it is currently written, provides many disincentives in development and operation of such a plan. First, we all know that the purpose of joining a group for health insurance is to spread the costs across a larger portion of the population, constituting the "risk pool". If Postmasters and other postal employees are taken out of FEHBP and placed in a separate corporate alliance, the "risk pool" will drop from the 9 million people now covered by FEHBP to the 700,000 employed by the Postal Service.

Second, the cost to the Postal Service of meeting the requirements for a corporate alliance are also daunting. Our understanding of the Clinton plan is that corporations which form their own alliances will not only be required to fund that alliance but will also be required to contribute 1 percent of their payroll to the regional alliances. The corporate alliance would also have to provide at least three separate plan choices including an HMO and a fee for service plan which would offer employees the option for employees to keep their own doctors. We agree that these choices should be available but we fear that covering these costs would greatly increase the Postal Service's operating costs.

If federal and postal employees are covered through regional alliances instead, each alliance would, as we understand it, bargain for coverage of its own alliance-wide health care costs. States would have a great deal of latitude in developing their own programs. These programs are expected to vary among the alliances. The Postal Service is unlike other employers in that its employees are spread throughout the country. This means that the Postal Service would be paying the employer's portion of health care costs into every single alliance in the country. Under the current structure, the federal government and the Postal Service pay a set amount of each individual employee's insurance. NAPUS believes that any future plan which is adopted should provide the same level of coverage for all postmasters whether they live in an urban or rural area. Yet this will mean that, because costs will vary, employer contributions will vary from alliance to alliance and employee to employee.

Also, NAPUS represents many retirees. Although current retirees have been grandfathered into the Clinton plan at the current payment rate, how will future retirees be treated? A number of our members opt to retire at age 55 or 60 and are not eligible for Medicare. Under the current system, they can maintain FEHBP coverage, but at a higher rate. We want to make certain that their health benefits would not be reduced or their costs increased prohibitively when they leave the Postal Service.

It is difficult to comment more specifically on the plan. While the percentage of employer compensation is set under the Clinton plan, no one knows the actual dollar amount federal and postal employees would contribute as co-payment because no one knows the total cost of services under this new health care system. If the 20 percent co-payment is significantly higher, in real dollars, than the same service is now, postmasters may feel that they are not well served by the plan. If it is only a few dollars higher than it is currently, they may not be upset by the change. Without knowing the dollar figures, we cannot predict their reaction.

As you have pointed out previously, Mr. Chairman, FEHBP has provided health benefits to federal and postal employees and retirees for the last 30 years. Several members of the Clinton administration have praised FEHBP for doing a good job of holding down health care costs. In fact, Mrs. Clinton has called FEHBP a good model for the health care system. It would be cruel to abolish a plan currently covering 9 million Americans without assuring those people and their families that their coverage will not be reduced or their co-payments arbitrarily increased. These people are currently being served. Why arbitrarily change their health program when it is working well? Other health care programs, such as CHAMPUS, have not been targeted for elimination.

We do not insist that the current program remain in existence nor do we oppose change simply because the program is as yet untested. However, the government has already spent millions of dollars over the last 30 years setting up FEHBP and developing the facilities, personnel and equipment needed to administer it. At this point, the administration has indicated that many parts of the plan, including the timetable for establishment of the regional alliances, are subject to negotiation. We urge this Committee to support legislation which would continue the FEHBP program at least until there are good working alternatives. Federal and postal employees should not lose their current coverage unless something at least equal to it can take its place.

We urge this Committee to remember our concerns as the administration's plan moves through Congress and we are very grateful to this Committee for providing us with an opportunity to offer our comments.

This concludes my remarks and I will be glad to answer any question you have.

Mr. CLAY. Thank you. Mr. Olvera.

Mr. OLVERA. Mr. Chairman, my name is Armando Olvera, president of the National League of Postmasters, and I am accompanied by Mike Sprague, general manager of the Postmasters Benefit Plan.

We salute the President for his desire to provide health security for all of this country's citizens, and we are willing to join him in the fruition of his goal. However, our commitment to a partnership approach is tempered with prudence.

Mr. Chairman, you are certainly to be commended for conducting these early hearings, in an effort to define a health care package that will accomplish this worthy goal.

We would hope that one of the principles of any proposed national health care system would be that it not increase current costs or reduce benefits. Postmasters are worried that a national plan would mean lower benefits with higher premiums.

Compared to the lowest cost option of the Postmasters' Benefit Plan, the Clinton plan represents a significant increase in expenses. We are concerned also for our retirees. We concur with the President's statement that the solution to today's squeeze on middle-class working people's health care is not to put the squeeze on middle-class retired people's health care.

While it is essential to seriously discuss and debate health care policy, and particularly the issues put forward in the administration's proposal, we question the wisdom of dismantling an existing system that meets the President's concerns and criteria for a national health care system, yet H.R. 3600 would close down FEHBP at the end of 1997.

OPM Director James King stated in his prepared text before this committee last November, that the FEHBP is a superior program because it exhibits many of the principles the President has identified as a foundation of the Health Security Act. FEHBP operates much like the regional health alliances the President is proposing.

Perhaps I am over-simplifying a very complex issue, but I seriously urge this committee to explore every possible means to retain the FEHBP as it is, or to at least incorporate it into any new system covering Federal employees and annuitants.

The National League of Postmasters sponsors a health plan which preceded the formation of FEHBP in 1959. The Postmasters Benefit Plan is self-administered. We employ over 100 people to maintain enrollment, adjudicate claims, handle customer relations and, in general, provide efficient quality service to our subscribers.

Of course, we have a genuine concern for these employees, and will do all we can to keep them gainfully employed. And our health benefits plan is only one of many plans in the FEHBP program. It wouldn't take much math to figure out how many workers would be displaced if the FEHBP is eliminated.

Thank you again for this opportunity to present our views on H.R. 3600. We are encouraged by your commitment, Mr. Chairman, not to abolish the Federal Employees Health Benefits Program unless you are sure such action is in the best interest of Federal, postal and retired employees.

President Clinton summed it up best when he said, "If your employer is providing good benefits at reasonable prices, that should continue." That is exactly what is on our minds. And, Mr. Chairman, the League will maintain an open mind and work with this committee as it seeks a solution to the legislative concerns of FEHBP subscribers. I will be open to any questions. Thank you.

[The prepared statement of Armando Olvera follows:]

PREPARED STATEMENT OF ARMANDO OLVERA, PRESIDENT, NATIONAL LEAGUE OF POSTMASTERS

Mr. Chairman, my name is Armando Olvera, president of the National League of Postmasters, and I am accompanied by Mike Sprague, general manager of the Postmasters Benefit Plan.

I am privileged to represent the Nation's postmasters along with thousands of retired postmasters, and I welcome this occasion to offer their views and concerns on

the President's National Health Care Reform Proposal: H.R. 3600, "The Health Security Act."

Postmasters, both active and retired, recognize that we are among the more fortunate citizens of this great Nation when it comes to health security for ourselves and our families.

We salute the President for his desire to provide similar health security for all of this country's citizens and we are willing to join him in the fruition of his goal. However, our commitment to a "partnership" approach is tempered with prudence. We do not envision a system that proves detrimental to our organization or those individuals we represent.

Mr. Chairman, you are certainly to be commended for conducting these early hearings, in an effort to define a health care package that will accomplish this worthy goal.

Hopefully, these hearings will answer the many questions postmasters have as to how national health care reform will work, how it will be implemented, how it will be financed, what it will cost, what it will provide, and most of all, how it will affect the present Federal Employees Health Benefits Program (FEHBP).

We would hope that one of the principles of any proposed national health care system would be that it not increase current costs or reduce benefits of those who now have them. Postmasters are worried that a national plan will mean lower benefits and higher premiums.

The chart of the following page compares benefits, cost-sharing, and limitations now offered under the PBP Standard Option to those proposed in the Health Security Act. As you can see, the Clinton plan, in many respects, represents a significant increase in expenses to enrollees in the lowest cost PBP option.

Yet, in the State of the Union Address President Clinton expressed the same concern when he stated one thing wrong with today: ". . . We're paying more and more money for less and less care."

What are we to believe?

	High Cost Sharing President Clinton's Plan			Standard Option Postmasters Benefit Plan		
Type of Service	Benefit	Co-Sharing	Limitation	Benefit	Co-sharing	Limitation
Inpatient Hospital (Room/Board)	80% after the $200 deductible is met	20%	Private room only when medically necessary	100% after $250 deductible (deductible waived when PPO is used)	$-0-	Private room only when patient must be isolated because of
Hospital Miscellaneous	80% after the $200 deductible	20%	------	80% (95% when a PPO is used)	20%	------
Professional Services (includes inpatient and outpatient medical professional	80% after the $200 deductible is met	20%	------	75% after the %300 deductible is met. (95% when a PPO is used)	25% (5% when a PPO is used)	------
Professional Service (surgery)	80% after the $200 deductible is met	20%	------	75% (no deductible) (95% when a PPO is used)	25% (5% when a PPO is used)	------
Emergency Services	80% after the $200 deductible is met	20%	------	100% (no deductible)	$-0-	Must be accidental injury treated on an outpatient basis within 72 hours of the accident. Treatment must be non-surgical

While it is essential to seriously discuss and debate health care policy and particularly the issues put forward in the administration's proposal, we question the wisdom of dismantling an existing system that meets the President's concerns and criteria for a national health care system.

As Congress proceeds toward developing a plan to provide universal, comprehensive coverage, we need to ask whether it is better to create an entirely new system with new plan administration or whether it would not be wiser to retain the experience and expertise of health plans long proven to be effective and then aim toward expanding what works to all. Interestingly, in his State of the Union Address President Clinton said, "Now our approach protects the quality of care and people's choices. It builds on what works today in the private sector—to expand employer based coverage, to guarantee private insurance for every American.

The Federal Employer Health Benefits Program affects the lives of 9 million people: employees, retirees and their dependents. In fact, you might say that these 9 million people already belong to a health alliance which offers universal coverage, comprehensive care, a myriad of choices, and protection against being denied coverage. Coincidentally, the FEHBP looks very much like President Clinton's idea of a health alliance. Yet, H.R. 3600, would close down the FEHBP at the end of 1997. Why? Just two weeks ago, our President said "From the day we began, our health-care initiative has been designed to strengthen what is good."

The FEHBP is the perfect model for other alliances. Administration spokesmen have concurred. The 30-year-old FEHBP has had its share of growing pains but has undergone corrections and improvements along the way, just as the proposed alliances are certain to experience for years to come. The FEHBP has experience and expertise which should not be lost.

OPM Director, James King stated in his prepared text before this committee last November that "The FEHBP is a superior program because it exhibits many of the principles the President has identified as the foundation of the Health Security Act. The FEHBP operates much like the regional health alliances the President is proposing."

It, therefore, appears to me that one approach should be to leave FEHBP as it exists and merely establish it as an alliance for all Federal employees and annuitants. Under President Clinton's proposal, companies with 5000 or more employees will be allowed to keep their existing health plans. Why then, not the FEHBP?

Again I would like to quote President Clinton: "Why do we want to guarantee private insurance? Because right now nine out of 10 people who have insurance get it through their employers. And that should continue." H.R. 3600 says one thing. The President says another.

What are we to believe?

Costs could be contained and coverage could still be universal if the Health Security Act, including the FEHBP as an alliance, is enacted.

Perhaps I am oversimplifying a complex issue, but I seriously urge this committee to explore every possible means to retain the FEHBP as it is or to at least incorporate it into any new system covering Federal employees and annuitants.

The National League of Postmasters sponsors a health benefits plan which preceded the formation of the FEHBP in 1959. Our plan was initially tailored to the needs of, and limited to, postmasters. Later it was expanded to make coverage available to all Federal employees and annuitants.

The Postmasters Benefit Plan (PBP) is self-administered. We employ about one hundred people to maintain enrollment and eligibility files, adjudicate claims, handle customer relations and in general provide efficient quality service to our subscribers.

We have a genuine concern for these employees and will do all we can to keep them gainfully employed. And keep this in mind: PBP is only one of the hundreds of plans in the FEHBP. It wouldn't take much math to figure out how many workers will be displaced if the FEHBP is eliminated.

Preserving FEHBP and its health benefits plans will preserve companies with years of experience and the jobs of those experienced employees. In our desire to improve the lives of many people through health coverage, we must be careful not to disrupt the lives of many others who could become displaced workers.

In any attempt to rewrite health care coverage as we know it, the League would have serious questions about the coverage of retirees, both those younger and older than 65. We hope that the Government continues to supplement the retirees' premiums and offer benefits identical to those they presently receive. We concur with the President's statement that "The solution to today's squeeze on middle-class working people's health care is not to put the squeeze on middle-class retired people's health care."

What are we to believe?

Thank you again for this opportunity to present our views on H.R. 3600, "the Health Security Act." We are encouraged by your commitment, Mr. Chairman, not to abolish the Federal Employees Health Benefit Program unless you are assured such action is in the best interests of Federal employees and retirees. President Clinton summed it up best when he said, "If your employer is providing good benefits at reasonable prices, that should continue."

That is exactly what is on our minds.

A mind is like a parachute—it works best when it is open. Mr. Chairman, the League will maintain an open mind and work with this committee as it seeks a solution to the legitimate concerns of FEHBP enrollees.

Mr. CLAY. Thank you. Mr. Palladino.

Mr. PALLADINO. Mr. Chairman, my name is Vince Palladino. I am president of the National Association of Postal Supervisors, and I am testifying today on behalf of 35,000 active and 3,000 retired postal supervisors and managers. With me today is my legislative counsel, Bob McLean. I will summarize.

In short, Mr. Chairman—and it will be very short—postal supervisors are concerned about the cost of health insurance for themselves and for their employer. If the Postal Service is to hold down postage costs, it must hold down health care costs. If postal supervisors are to meet their financial obligations while raising their families, they must keep their health insurance premiums cost-manageable.

As managers and insurance buyers, we have a dual interest in health care reform that controls cost. For those reasons, we have, along with many other employer organizations, called for the reform of FEHBP. We have not called for its elimination, and we remain unconvinced that it is necessary to eliminate it to control health care costs.

We do not believe that a smaller cooperative such as a postal health alliance would be a smart move either. In short, supervisors, active and retired, do not want to pay more and get less. If the Clinton plan can ensure that that doesn't happen and controls health care costs, we will support it.

We look forward to receiving additional details on the Clinton plan, including the Congressional Budget Office's analysis, due out this week, so that we may provide additional commentary on the value of the reform proposal. Thank you. I will answer questions.

[The prepared statement of Mr. Palladino follows:]

PREPARED STATEMENT OF VINCENT PALLADINO, PRESIDENT, NATIONAL ASSOCIATION OF POSTAL SUPERVISORS

Mr. Chairman, My name is Vince Palladino, and I am president of the National Association of Postal Supervisors. Today I am testifying on behalf of over 35,000 active and 3,000 retired postal supervisors and managers. We appreciate the committee hold this hearing, which will provide us the opportunity to discuss some of our concerns and objectives in the ongoing health care reform debate.

We find ourselves in the unusual position of testifying at a point in this debate well after most of the major reform proposals have been introduced, but before some of the most pertinent details for each have been released, in particular their projected costs. And we are not only concerned about the cost to the individual.

As an association representing the majority of supervisors and managers within the Postal Service we are extremely concerned about the impact of health care reform on the financial stability of the institution we serve, one which has experienced a tremendous increase in health care costs over the last decade. During that same period there has been increasing pressure to hold down postage rates while facing billion dollar payments to the federal treasury that were unanticipated. Controlling future health care costs is essential to ensuring the future financial stability of the Postal Service, as well as its ability to remain competitive.

As an association representing the individual concerns of almost 40,000 current and retired health care purchasers and users, we must also confront the double-digit increases in health insurance premiums our members have experienced several times during the past decade. They are as concerned about their own out-of-pocket expenses as they are about maintaining adequate coverage for themselves and their dependents.

So our overriding objective as a participant in the health care reform debate is to find a solution which responds to the very real institutional concerns of our members' employer, while providing a sense of security at a reasonable cost for our members and their families. The question for NAPS' members, then, is will the Clinton proposal respond to these concerns. We can provide an answer that is only as detailed as the President's proposal.

The most significant feature of the Clinton plan, as far as postal supervisors are concerned, is the elimination of the Federal Employees Health Benefits Program (FEHBP). NAPS was one of many groups which testified before this committee several times over the past five years of the need for reforming FEHBP. We did not call for its elimination then, and we question the wisdom of eliminating it now.

The need for reforming FEHBP was made clearer to us than most other postal and federal employee organizations. Many of the newer committee members may not be aware that from 1980 until 1990 we sponsored the Supervisors Health Benefits Plan, and FEHBP participant initially open only to postal supervisors, then later to all postal and federal employees. Membership began at 2,000 members and reached a high of 83,000 members. Our success in attracting enrollees would ultimately lead to the closing of our health plan.

We attracted so many members because we were a "benefit-rich" plan, offering excellent coverage at a relatively reasonable price. But those benefit levels and premium costs attracted the attention of many individuals who required frequent medical attention, causing our claims totals to skyrocket. Each year we experienced higher claims, which forced us to pass along higher premiums, which resulted in fewer enrollees. Many of our enrollees were refugees from other plans, which they had to leave because they had reached the annual catastrophic limit. Once they joined our plan, many of them again reached this limit, sometimes in only a single year. We were forced to close the plan because our underwriters projected another huge decrease in membership, and an equally large increase in premiums.

What happened to the Supervisors Health Benefits Plan highlights some of the major weaknesses of FEHBP, but the program is not without positive features. Through FEHBP, postal and federal employees enjoy many of the features the president has put into his own reform proposal. We have universal coverage; employees cannot be denied coverage and there are no restrictions because of preexisting conditions. We have choice; while a number of participating FEHBP plans have closed in the last five years, there remains a broad variety from which to choose. Coverage in retirement is guaranteed; once you belong to FEHBP, your coverage cannot be revoked, as it sometimes the case in the private sector.

Like other health insurance programs across the nation, however, FEHBP has not been able to hold down health care cost increases to level below the general rate of inflation. The question, then, is whether the Clinton proposal provides the answers to the problems in both the public and private sectors. The lack of specifics, particularly estimates on premium costs, makes it impossible for us to give the committee a definitive answer. We can make some broad observations about the proposal.

1. We support the president's call for universal coverage that can never be revoked. While not everyone in this country pays insurance premiums, everyone has access to medical treatment, and those of us who are employed and who pay taxes are already subsidizing those without jobs or who are without jobs or who are without coverage. A national health care program that would provide coverage in a more systematic way is not only the morally correct thing to do, it will probably distribute the cots of providing coverage on a more equitable basis.

2. We do not see the need to eliminate FEHBP completely. If an FEHBP health care alliance offers the same standard benefit package as other alliances, then any accusations of Congress taking care of itself first would be nullified. However, if Congress does eventually endorse this recommendation, the conversion from this program to the new health care alliances should not be mandated until all fifty states and the territories have all their alliances in place and operating.

3. Retirees, current and future, must be protected as well as employees. We are concerned by all of the talk of supplemental programs for future retirees, and statements by OPM and Health and Human Services Department officials about public

perceptions that federal employees may receive a better benefits package than private sector employees. During this Congress alone we have seen a number of employee and retiree benefits come under attack. We do not want to see a new system established with supplemental benefits that in the future could be cut back or eliminated for political or economical reasons.

4. Most NAPS members are located in large metropolitan areas, but we are concerned about those few supervisors who live in rural areas. In urban locations our concern is that premium costs may be exceptionally high if the city is its own alliance. As one of the federal unions pointed out in November, employees who live in a city like Washington, DC—which will probably be its own alliance—may have a significantly higher premium cost than the surrounding areas in Virginia and Maryland. In rural areas, premium costs will be lower, but how far will our members have to drive to reach the individual or facility that is participating in the appropriate alliance? And what will be the cost for those who live within an alliance that crosses state lines? These are questions that need to be answered, but the administration has yet to provide specifics in this area.

5. We do not see the need for a Postal Service health care alliance. The agency does not currently have the expertise to administer such a program, and we have not seen, up to now, any evidence that such an alliance would be economically attractive. As important, after experiencing a painful reorganization resulting in the elimination of much of the bureaucracy, we do not see any cost benefit to adding a new bureaucracy to oversee health insurance. As an employee organization without a health plan, we have no desire to reenter the health care business, even though a postal alliance might offer NAPS such an opportunity.

6. Finally, and most importantly, we will not support a proposal that has our members paying more and getting less, and this appears to be the situation with the Clinton proposal as it was initially released. The best example of this, highlighted during the committee's November 18 hearing, is the reduction in coverage of inpatient hospitalization form 100 to 80 percent. This represents a serious degradation in the quality of coverage for our members, and raises everyone's suspicion about other, less obvious cost increases that may result from the Clinton plan. It is our hope, and should be the administration's goal, to increase benefits through the increased efficiency of a national program, particularly in such areas as mental health and long-term care.

In closing, Mr. Chairman, let me again note that our testimony cannot be more specific because we are reacting to proposals which lack specifics, especially in terms of the cost of health care reform. We believe our concerns and our hopes for a reformed health care system are not unique among Americans, but we also believe that as federal employees we enjoy the benefits of a unique health care program, FEHBP. It should not be eliminated without ample evidence that it replacement will provide the same level of benefits and the same cost.

Mr. CLAY. Thank you. I see that all three of you have expressed some serious concerns and doubts about dismantling FEHBP. Mr. Games, what are your chief concerns with the possible dismantling of FEHBP and enrollment of your members in either a postal corporate alliance or a regional alliance?

Mr. GAMES. Mr. Chairman, I guess our main concerns are that we feel like the FEHBP plan right now is pretty good. Our members, the postmasters and retirees, from around the country are satisfied right now with FEHBP and what benefits they receive from that, costwise, benefits-wise and whatever. What our fears are of the unknown. We don't really know what is coming yet, and it's really hard to address that issue until we know more about it. But we just want to make sure that we get at least what we've got now. But we're open to the change, we're open to whatever may be coming, as long as it's as good as what we've got right now. I don't know how to answer it any differently.

Mr. CLAY. How would your membership feel about what Ms. Norton said just at the end of the last panel? Would they be willing to accept a slight decrease in benefits or choice to make sure that everybody is covered?

Mr. GAMES. I think our membership is interested in everybody having universal health care. No, I don't think that they would be willing to take any kind of a hit. They feel like they've been taking hits right along the last few years, and this is something that they feel is part of their employment and they would like to keep.

Mr. CLAY. So, I guess, basically, what you are saying is that you think there should be universal coverage, but everybody else's benefits should come up to FEHBP's standards.

Mr. GAMES. That's right.

Mr. CLAY. How do you feel about that, Mr. Palladino?

Mr. PALLADINO. Well, that's a pretty tough question. I'm not sure. Our members might be willing at least to break even on it, to support it. I don't know how much—I guess I would be like Socrates, and ask a question to a question. How much of a hit are you talking about?

Mr. CLAY. I don't really think that that's the only option but, in case it is, I would like to know what your opinion is. I think there are other options in which we can have universal coverage without reducing the benefits of Federal employees.

Mr. PALLADINO. I think that's what we're hoping for. I like Eleanor Holmes Norton's proposal that we take a look at it later, when we——

Mr. CLAY. You like her proposal.

Mr. PALLADINO. Well, we won't get into that, but I'd like taking a better look at the Clinton plan later and making a decision, to see if they can—if they can control the costs and it can do good, I'm sure we'll support it.

Mr. CLAY. Mr. Olvera, would you like to comment?

Mr. OLVERA. Definitely, the preliminary figures on benefits under Clinton's health plan are very much less than what our members are receiving now. Although, I strongly believe our members would want to support the President and universal coverage, I don't believe any one of them, asked individually, would be willing to give up what they have now. And although we've had problems with FEHBP over the years, I think the last few years have been really successful in holding our costs down.

And I guess the membership that would be hurt the most would be our retirees.

Mr. CLAY. Thank you. Mrs. Morella.

Mrs. MORELLA. As I understand it, you, like all Americans, just feel we want to continue to at least have what we already have, we don't want to see the benefits lessened, or even the premiums to rise, but we do like universal coverage, is that correct?

Mr. GAMES. Correct.

Mr. OLVERA. Correct.

Mrs. MORELLA. Thank you. Thank you, Mr. Chairman.

Mr. CLAY. Thank you. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman. I regret I have an intervening hearing that——

Mr. CLAY. Are you getting ready to ask questions?

Mr. GILMAN. I'd like to ask a question.

Mr. CLAY. You'll have to wait your turn, Mr. Gilman.

Mr. GILMAN. I'll be pleased to.

Mr. CLAY. This is Ms. Norton's time.

Ms. NORTON. Mr. Chairman, I just want to amend what the Chairman said. My hypothetical did not pose a reduction in benefits, but a reduction in choices, and I have a feeling that there are not going to be "50-11" choices, that there are going to be fewer choices, and one of the things we may have to ask ourselves, in light of the large number of working people who aren't covered, is whether or not we'd embrace a reduction in choices, that might not leave us with fewer benefits and might not leave us paying more, but would narrow our choices. And I don't know if that's going to be necessary. I mean, I'm like you all, I do not know how this is going to fall out. But I think that we need to start thinking about it now, and the slogan's perpetuate the notion, really, that there's a free lunch, that we can get universal health care and no sacrifice of any kind is going to be necessary.

I don't believe that the administration means to do that. I think what it's trying to do is to first galvanize a majority for universal health care that cannot be lost, and then, logically, to go into the details of how that is possible. I'm just afraid it will come back to bite them. And somebody will say, "Yeah, but how I understood that was that I really wasn't going to be losing anything I have now." And while I don't know that we will, as we get into the details, I don't want any surprises for you, for me, and, heaven knows, for the American people, who might then slip away from even the notion of universal health care for all that you can't lose.

I just have one question. I anticipate that the chairman, and I, and all of us who have certainly not come out for eliminating FEHBP, the one plan we know in this country that works, but do not want to see FEHBP dismantled willy-nilly, and certainly not piecemeal, before we have in place a coherent system that we know works.

The notion of not dismantling FEHBP at all, which several of you have testified to, is for many unfair, discriminatory treatment. So, first, we've got to meet that. But let me read to you the other argument we're going to reach because you would have thought that the argument of at least not dismantling FEHBP, presto, would be all right. This is a Letter to the Editor from the Washington Post, last week, and I'm reading a couple of sentences. This is February 4, Washington Post, Letter to the Editor.

> If things go according to the Clinton's plan, we will be covered by some sort of universal health care system by the end of 1994. Universal, except for 9 million Federal employees, retirees, and dependents, who will continue their coverage until 1998, well after the rest of the Nation is scheduled to begin the largest health care experiment in history.

I can hear them now, can't you, Mr. Chairman, on the floor, that all of them have to jump into the unknown, and they will not say it is you who are not jumping into it. They will not say it is Federal employees who are not jumping into it, they will say it is Congress that is not jumping into it because we are covered, of course, by FEHBP.

I have just been a member of the Joint Committee to Reorganize the Congress and, of course, I supported, as I think most of my colleagues do, the notion that Congress ought to be brought under the same laws as everybody else.

I'd like your help in trying to explain and to argue for what I truly believe is that FEHBP should not be dismantled at least until—at least until—all the alliances are in place, and how do we separate FEHBP from all of the other plans that are in existence.

Now, let me give you a hint. I have two arguments thus far, and I'm looking for others. One is that FEHBP works, and it works at lower cost, so there's nothing to be gained by taking this system apart. The other goes to the stability of the plan. We're talking about employees located in every conceivable jurisdiction in the United States of America. We'd be hard pressed to find a private employer who is literally located in every little town and village the way Post Office is, and in every large city, and that the coherence of a plan requires that we hold it together until the alliances are in place because we will be sorting out so many disparate parts and components. Now, if you've got anymore arguments, I'd be glad to hear them. I need them.

Mr. CLAY. Anyone care to answer?

Ms. NORTON. The question is, why FEHBP should be held in place and other plans be dismantled, to set up the new Clinton plan.

Mr. OLVERA. Possibly, one reason would be that the Clinton plan says that companies with 5,000 or more employees are exempt from joining alliances. That should apply to the government and Postal Service, too. If, in fact, the FEHBP program was dismantled and you had different Federal employees and postal employees across the country, and the Postal Service declined to form an alliance, they would be paying different rates because their alliances are in different parts of the country. Postal employees do not have area type wages. Everybody makes the same hourly rate. This possibly could cause employees in North Dakota to pay a higher or lower premium than somebody in the New York area. How would it be fair to our Federal and postal employees in that they would be paying different amounts for their health care?

Ms. NORTON. You reminded me of the 5,000 employee exemption, in the first place. Thank you, Mr. Chairman.

Mr. CLAY. Thank you. Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman. I want to welcome all of our distinguished panelists here, and the prior panel that you had. I've been reading the testimony. Apparently, the general consensus is, let's not destroy what we have until we are assured that we're not going to lose anything under the new plan. Is that pretty much the thinking of most of our organizations that are affected in the Postal Service? And I think that we want to make certain, too, in the committee, that you're not going to have any imposition. And there is a great deal of concern out there amongst the Federal employees throughout our Government, of how it's going to affect all of them. And I know that you have significant plans.

I hope, too, that you would come out in strong support of something I've been vitally interested in that's part of the President's plan, and that is preventive health care, and whatever program we adopt, we would like to see great emphasis on prevention, by making certain that there's going to be provision for taking care of annual checkups to prevent the more serious illnesses from occurring.

And, too often, in any of the providers' plans, there isn't that provision, and I think that that's good insurance, to make certain up the road we don't have a more serious illness to contend with.

And then, too, we want to provide the security for the retirees who leave the Service, to make certain that they are not going to lose out by having to give up their employment, and I think that that security provision is extremely important.

So, we welcome your input. We're just beginning to get into the various proposals that are out there. As you know, there are seven or eight major proposals. Many of us are hoping we can put the best of all of them together, to come up with a good, sound, cost-effective, affordable program, with quality care and availability to all.

And so as we move ahead in the next few months, please let all of us know, particularly those of us in the committee, how this will affect our Postal Service employees. I thank you, Mr. Chairman, for arranging this panel.

Mr. CLAY. Thank you. Let me ask this question. Under the bill, the Postal Service has the option of either operating a corporate alliance or enrolling its employees in a regional alliance. Consequently, the postal work force must understand the pros and cons of both of these options.

Have any of your organizations been able to determine yet which option, corporate versus regional alliance, is better overall for your members? Mr. Palladino.

Mr. PALLADINO. We don't see any benefit to the Postal Service to go out on its own.

Mr. CLAY. To have what?

Mr. PALLADINO. To have its own alliance, because it's going to cost money.

Mr. CLAY. You prefer the——

Mr. PALLADINO. Well, I prefer—when the Postal Service doesn't do well, then the prices of stamps have to go up, and everything generates up. I'd rather see us not have that extra cost.

Mr. CLAY. Mr. Olvera.

Mr. OLVERA. I disagree. I feel that the Postal Service should have its own alliance. I don't think the cost would be that much different to the Postal Service, based on whether they would be paying their share on a regional basis or on their own health alliance plan.

Mr. CLAY. Mr. Games.

Mr. GAMES. I guess we do have some concerns about a corporate alliance, a postal corporate alliance. Whether the Postal Service wants to do that and take on that responsibility but, also, when that happens, the risk pool would be reduced from 9 million, as I understand it, to about 700,000 people, which could make the cost go up significantly.

The plan could be too costly to develop. The 1 percent of payroll to the regional alliances and whatever is a big expense the Postal Service would have to take on. And then, also, we see that they'd probably have to have at least three separate plans—the HMO, the PPO, and some kind of a fee-for-service plan. So, it would be quite a bit to take on, and we don't know right now whether they are even willing to do that.

Mr. CLAY. Thank you. Any further questions? Ms. Norton.

Ms. NORTON. No further questions, Mr. Chairman.

Mr. CLAY. Thank you. Certainly thank you for your testimony.

The next witness is Mr. Joseph Mahon, Jr., vice president, labor relations, U.S. Postal Service. Welcome to the committee and, without objection, your entire statement will be included in the record. You may proceed as you so desire.

STATEMENT OF JOSEPH MAHON, JR., VICE PRESIDENT, LABOR RELATIONS, U.S. POSTAL SERVICE

Mr. MAHON. Thank you, Mr. Chairman. I have no desire to read my statement, which you've already admitted into the record. I want to express our appreciation for your careful consideration of this very complex issue, and especially for allowing us to give you the Postal Service's perspective.

We tried, in our testimony, to give you a unique perspective, something beyond the prior testimony, and I would just like to make a very few, hopefully succinct, hopefully clear, points in summary.

First of all, a number of years' ago, the Postal Service did undertake a study of whether or not it would be feasible for the Postal Service to have its own plan, through negotiations, of course, that consisted just of the postal population.

The findings were very complex, but two messages came through loud and clear. No. 1, our population demographically was younger and healthier than the Federal population as a whole. So, from that standpoint, the endeavor would have been feasible. What stopped us was a change in the financial accounting standards which would have required us to accrue the medical costs for future retirees.

The first year impact of that would have been devastating on postal prices. Some had predicted that the price of the stamp to cover that first year impact would have risen 4 cents, which would have been very devastating to our competitive position. So, that effort was terminated for that reason.

In the meantime, the performance of FEHB improved considerably, and the rates of increases dramatically reduced in recent years. I believe that there was improved administration, and there were elements of managed care that were introduced, and I'm sure that there were some adjustments of benefits as well, but our recent experience has been that even though the rates of increase still have exceeded the rate of inflation—which, of course, is not acceptable—that the recent performance of FEHB is far better than what we were experiencing when we decided to pursue a study of the feasibility of a separate postal plan.

Like many of the prior witnesses, we're not precisely sure how we would stand under a corporate alliance or a regional alliance setup under the proposed legislation which you are considering.

From our vantage point, one of the big uncertainties is the treatment of retirees. We're not sure, for example, whether or not in proposing that the Postal Service, like large private sector employers, could form its own corporate alliance, whether the treatment of postal retirees would be identical to the treatment of retirees in the private sector.

Let me just cite very briefly some of the concerns that we have with regard to a corporate alliance. The 1 percent tax, of course, would be considerable. If we have responsibility for retirees under a corporate alliance, then we're still faced with the FASB problem, as we've called it. We would no longer have the multi-employer exemption that we now enjoy as a result of participating in the FEHB Program, and we might have that one time dramatic increase of future accrued medical costs. So, we're still very concerned about that.

A corporate alliance, although many large employers look upon that as a favorable option, becomes very complex when you operate in many different States, and become extremely complex when you operate in all 50 States, as we do. And it does not appear to us that to get from here to a single Postal Service only plan is going to be all that easy.

No. 1, because of the States' regulation of corporate alliances, if we selected providers that were certified in some States but not others, then we would have to sit down and arrange and negotiate alternative provisions in the State where our selected provider did not receive certification.

The same thing would be true with regard to those States that followed the single-payer approach; our plan would have to give way to that option in States or regions where that option was selected.

So, in brief, as my colleagues who have preceded me have made clear, it is not crystal clear what the future holds. We support the notion of universal protection, and I think Member Norton really hit the nail on the head, that you cannot achieve major change without people being impacted.

One thing was learned at the Postal Service in the past year, and we've experienced much change there, is that people embrace change as long as they don't have to do anything differently, and you don't get change without people doing things differently.

But like the others, from our standpoint, we would like the flexibility to watch this legislative process unfold, and to provide any further assistance that we could to this committee, and to have the flexibility to negotiate the best plan for the Postal Service, its customers, and its employees.

Thank you very much for allowing me to be here today, and I'll try to answer any questions you have.

[The prepared statement of Mr. Mahon follows:]

PREPARED STATEMENT OF JOSEPH MAHON, JR., VICE PRESIDENT, LABOR RELATIONS, U.S. POSTAL SERVICE

Mr. Chairman, My name is Joseph J. Mahon Jr., and I am the Postal Service's Vice President for Labor Relations. I am honored to appear today before your committee on behalf of the Postal Service. At the outset, I want to congratulate you for scheduling this series of hearings to focus on the best method to secure adequate health care for all Americans—a goal that all of us can agree upon. I have been invited to discuss with you and the Committee the options available to the Postal Service under the Administration's health care proposal.

Like every other responsible employer, the Postal Service is concerned about the proposed reform of the American health care system, and about providing the continued benefits of health care to its employees. Because of our unique status as a self-supporting service establishment within the federal government, we share with every private-sector employer a desire to moderate the health insurance costs—including policy premiums and administrative expense—that we incur and must in

turn pass along to our customers. These costs are especially important to the Postal Service as an employer of over 700,000 workers. Our mission is to provide an affordable public service to a customer base that is far larger than that of any private-sector business: the entire American people, who are touched by the mail service every day.

As a matter of practical economics, neither we nor our customers can continue to absorb health care cost increases that substantially exceed wage increases and inflation generally. In 1986, the Postal Service's health care costs for its employees and their families were $899 million. In 1987, the Postal Service also began to pay health care costs for its retirees. By 1993, the Postal Service's costs for its employees and retirees had risen to $2.845 billion, including $510 million for retirees. Over that seven-year period, our total cost grew by more than 216 percent, and the compound annual increase in costs was almost 18 percent.

Along with other federal employers, the Postal Service participates in the Federal Employees Health Benefits Program (FEHBP). Unlike other federal employers, however, we determine the level of our employer contribution for the FEHBP health benefits of most of our employees through collective bargaining with the four postal unions and consultation with the three management associations.

The range of plans available under FEHBP allows our employees to tailor their own coverage to fit their health care needs, as well as their financial means. They have a choice among seven national indemnity plans, some with high and low options, that also offer preferred provider organization (PPO) network benefits and health maintenance organizations (HMOs). In the past several years, FEHBP has done a good job of introducing cost-control measures that have worked to the advantage of the Postal Service as well as postal employees. From management's perspective, those measures have led to important reforms such as managed care and preferred provider options. We note that the rate of increase in FEHBP costs has slowed while the level of benefits has remained competitive with the private sector.

The Administration's health care proposal would abolish FEHBP and bring federal employees generally into regional health alliances. But it would also preserve for the Postal Service the options of entering the proposed regional alliances or setting out on our own to form a corporate alliance. Under the bill, the Postal Service would be able to weigh the advantages—and disadvantages—of each course of action, and make the wisest choice for our employees and ultimately for our customers.

We have begun to explore this choice between corporate and regional alliances. From the beginning, however, our analysis is subject to certain constraints. Unlike other large employers that are eligible to establish corporate alliances, we do not have access to claims utilization data for our own population. With that data, we would be able to determine more precisely the relative costs to the Postal Service and to our employees of participating in the regional alliances versus a corporate alliance.

Without such data, we must rely on general demographic data to make cost projections. Our actuaries have made a first cut at such a comparison for our active employee population, and it is not surprising that our employees mirror America.

If that means (as we believe it does) that our average per-person benefit costs for healthcare will be roughly the same whether we participate in the community-rated regional alliance systems or establish our own corporate alliance, it requires us to think very hard about two types of non-benefit costs associated with setting up a corporate alliance. First, how could the Postal Service justify paying the required additional one-percent payroll tax? For the Postal Service, based on current pay levels, this cost is approximately $300 million annually. We would be hard pressed to find other savings from forming a corporate alliance that would offset that cost.

Second, other large employers already have in place the resources and infrastructure to administer their own health benefit programs. We have none because, like other federal employers that participate in FEHBP, we rely on OPM's staff and actuaries to provide those services. Given the geographic spread of the Postal Service's operations and the requirement in the Administration's proposal that a corporate alliance offer employees at each location a choice of at least three plans, it would require a substantial effort to replace the excellent resources now in place at OPM. These requirements could also add materially to the cost of providing health benefits to our employees, compared with either maintaining FEHBP in some form or participating in regional alliances.

Numerous other factors must be considered before we decide which option is best for the Postal Service, its employees, and postal ratepayers. The primary factors include the overall cost of corporate versus regional alliance participation, the adequacy and potential variety of health benefits offered, the proper accounting treatment for each option (which will affect postal rates), and the features of our collective bargaining process that most private-sector employers do not confront—in particular, the concept of interest arbitration.

We have been holding informal discussions on these issues internally and with our benefits consultants and external auditors. In addition, by law we are required to bargain with the postal unions and consult with the management associations over substantive changes in health benefits. Furthermore, it would be premature at this time to commit to any one approach because the final health care reform bill may differ significantly from the current proposal.

Indeed, the Administration's proposal leaves open a number of substantial cost questions. For instance, covering our temporary employees could add considerably to our expenses. Currently under FEHBP, any temporary employees who are eligible to participate must pay the entire premium, without an employer contribution. Under the Administration's proposal, even if an employer formed a corporate alliance, it would still be required to make an 80 percent contribution to regional alliances to reflect the full-time equivalent of its temporary workforce. An employer in a corporate alliance would end up participating in the regional alliances as well. We join the Administration in recognizing the importance of health care availability for everyone; but as an employer responsible to the ratepaying public, we are concerned over the cost implications of such provisions.

How the Administration's plan handles retiree health care costs is especially important in light of the growth in those costs that has been imposed on the Postal Service under recent Omnibus Budget Reconciliation Acts. Before 1987, the Postal Service, like other employers in the FEHBP system, was not required to make a direct contribution to the employer's share of retiree health care costs. But starting in 1987, the Postal Service was required to contribute the employer's share for newly retired employees, and our share of retiree health benefits costs has been further increased in subsequent budget reconciliations. Thus, a cost that did not affect our operations at all in 1986 had increased to $510 million by 1993 and is projected to exceed $1 billion by 1997. We note that the Administration's proposal would add between $3 million and $6 million to this cost in 1997 by accelerating the date of our final payment under the 1993 budget reconciliation.

As the Committee is no doubt aware, the Postal Service in the recent past seriously reviewed the possibility of establishing a health benefits program separate from FEHBP. That consideration was driven in large part by our concern about the pace of increases in FEHBP premiums in the late 1980s (which have since moderated). The key factor in our decision to remain within FEHBP was the issue of retiree costs, and that issue will continue to be of critical importance to the Postal Service as we assess the potential impact of the Administration's proposal on our operations.

The problem of retiree health care costs is compounded by the Financial Accounting Standards Board's FAS 106, issued in 1990. This statement set forth new rules for accounting for post-retirement health benefits, and effectively requires employers who maintain such benefits to book the cost of those benefits on an accrual basis, rather than simply booking cash payments, as was previously permitted.

Even before this standard was issued, we had engaged actuaries to determine the potential effect of accruing retiree health benefits costs. The results of their studies showed that if we were required to book health benefit liabilities for retirees, the expense would be about $5 billion annually and would exert significant upward pressure on postage rates.

Under FAS 106, however, so-called "multi-employer" plans are required to continue to book cash payments rather than these accrual basis costs. We concluded, and our auditors concurred, that FEHBP operates in substance as a multi-employer plan from the Postal Service's point of view. Consequently, remaining in FEHBP offered significant accounting advantages that we would lose by creating a separate program.

It is not clear whether FAS 106 would require accrual for retiree health benefits offered under a separate postal corporate alliance plan, or whether it would apply to our participation in the regional alliance structure. In addition, the impact of supplemental benefits plans and the temporary assessment on employers with retiree health benefits costs further complicate the picture. We will be reviewing this issue with care over the coming months.

We note that another proposal, H.R. 3222, introduced by Representative Cooper, would appear to require us to prefund retiree health benefit liabilities; this would have serious consequences for the Postal Service.

Finally, we note that the Administration's proposal would direct OPM to develop and offer to federal employees one or more supplemental plans that would preserve the overall level of benefits previously afforded under FEHBP. Because of our concerns about health benefits costs, at this juncture we would prefer not to be required to participate in those supplemental plans or, at least, not a prescribed contribution level.

As the Administration's health care reform proposal makes its way through the legislative process, our most important request is that the Postal Service retain the flexibility to choose the most beneficial approach. Our objective will be to retain the widest variety of options to help the Postal Service continue to control overall health care costs, and maintain affordable postal rates, while providing our employees with an overall benefits package that they deserve.

That concludes my prepared statement, Mr. Chairman. At this time, I would be glad to respond to your questions.

Mr. CLAY. Thank you. With respect to the difficulties that you would have in setting up a corporate alliance in 50 different States, do you have any idea how much it would cost the Postal Service to assemble the staff and build the infrastructure to operate a corporate alliance?

Mr. MAHON. That would be a hard number for me to give you right now, but it would be considerable, Mr. Chairman. We have had the benefit of not needing a great deal of in-house expertise regarding the administration and the benefits end. All that we did was negotiate how much we were going to contribute toward employee health plans, and then to set up a mechanism for making sure that that contribution was accomplished. But we would have to add considerable administrative staff in order to participate either as a corporate alliance or become members of the various regional alliances.

Mr. CLAY. Inasmuch as the ultimate decision to elect to run a corporate alliance will involve a combination of collective bargaining, with four unions and three associations, to what extent have you involved those parties in your preliminary analysis?

Mr. MAHON. Well, we shared with all of the unions who were interested in it, our exploratory efforts toward a single Postal Service plan, and even after we concluded that FASB constituted a major obstacle to pursuing it, we continued discussions with the NALC and the APWU. They were very interested in a postal only plan.

Let me make this observation, and maybe the experience this morning might confirm its accuracy. Dealing with a single union representing all of its employees would be much easier in accomplishing a corporate plan, than dealing with four separate organizations that represent the bargaining unit and three separate organizations that represent the management portion of our work force.

There were varied opinions and feelings and values and attitudes expressed here this morning, and I can assure you that those differences show up at the bargaining table, as they have when we were discussing these issues with the union. But we recognize—and I think we have the foundation set for good faith collective bargaining on these and all issues relating to postal employees, with the gentlemen who appeared before you this morning.

Mr. CLAY. Yes. Many large firms have to deal with more than one union, and we've found that those problems haven't been insurmountable.

Mr. MAHON. Can I make one observation on that point?

Mr. CLAY. Certainly.

Mr. MAHON. You are accurate, without a doubt, on that point, but there is a difference between a firm operating in the private sector, that has total control over what it wants to pay and how it wants to pay it, and it can put a uniform proposal before seven unions, negotiated maybe with the largest of them, and say, "It makes sense for us to have a single plan, we're not going to have seven different plans," and then the unions are faced with whether or not they want to go out on strike to get something different.

The possibility of differences—and this is why we alluded to it in our prepared statement—is very much greater where you are dealing in the area of interest arbitration because each union does not break an impasse by going out on strike or making a determination to go out in strike. It breaks the impasse by going to arbitration.

Each of them has the right to go to a separate arbitrator, and our experience has been that that second arbitrator doesn't have—how shall I put it—it doesn't automatically want to just rubber stamp the decision of the award that came out previously.

So, there is—your observation is correct. I just think that there's a slightly different slant on that issue when you're talking about collective bargaining that ends up in interest arbitration.

Mr. CLAY. Well, to clarify the record, you are not recommending that postal workers have a right to strike, I hope.

Mr. MAHON. I don't think it would be feasible, but I have an open mind.

Mr. CLAY. Speaking of interest arbitration, I understand that an interest arbitrator instructed the Postal Service to participate in a committee, along with the APWU and NALC, to devise a separate postal plan for consideration by the parties. Such a plan was to be prepared by the end of this year. Has that process begun?

Mr. MAHON. It really hasn't got very much underway, and we need to address that issue.

Mr. CLAY. Do you have any idea when you will begin?

Mr. MAHON. Well, I have invited my two colleagues, that if they can get together on a date and a procedure, that we will be there, and I don't want to get in too deeply to what's been going on in the labor scene at the Postal Service, but I hosted and arranged all of the meetings that we had during the interest arbitration procedure, and it's often hard to get the parties together. But we'll get together, and we'll get that process underway, and we'll agree among ourselves, I'm sure, what we want to do. I doubt very much that we're going to need any outside third party assistance on this.

Mr. CLAY. In your statement, you said that the Postal Service is opposed to being required to offer and pay for supplemental benefits for its employees. Yet it's possible that under the bill's standard benefit package, your employees could suffer a loss of some benefits and an increase in out-of-pocket cost.

Now, isn't your statement in conflict with the rights of postal employees under the Reorganization Act?

Mr. MAHON. No. All that we're saying is that we shouldn't be mandated to do it legislatively, but we're not saying we shouldn't be required to bargain about it if it's a bargainable subject.

Mr. CLAY. But you can't reduce benefits, can you?

Mr. MAHON. Reduce benefits? Yes. Collective bargaining can result in a reduction of benefits, without a doubt. In fact, we just, to some degree, accomplished that in the last interest arbitration we had on health benefits, in that we brought our contribution level back down closer to what the Federal Government pays. So, I think some would characterize that as a reduction in benefits, but collective bargaining is a two-way street, without a doubt. That is, by the way, why I didn't say categorically from a collective-bargaining standpoint, that it would be a bad thing to have postal employees given the right to strike.

There are many other implications, involved in Postal employees having the right to strike, and I'm not advocating it, but, during the 1970's, the unions that had the right to strike were riding high; however the economic trends have turned quite a bit now. I think a lot of unions that have the right to strike would rather have the right to go to interest arbitration.

Mr. CLAY. The right to what?

Mr. MAHON. The right to go to interest arbitration.

Mr. CLAY. But if my bill passes, striker replacement, they'd rather have the right to strike, wouldn't they?

Mr. MAHON. Maybe so. Maybe so.

Mr. CLAY. Are there anymore questions? Did Mr. Gilman have any questions he wanted to ask?

Mr. FISHER. No.

Mr. CLAY. Well, if any other member of the committee has any questions, we'll submit them to you in writing.

Mr. MAHON. Please get back to us, and thanks again for inviting us.

Mr. CLAY. That concludes the hearing.

[Whereupon, at 12:18 p.m., the committee was adjourned.]

[Additional material received for the record follows:]

PREPARED STATEMENT OF HON. GARY L. ACKERMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I would like to welcome our distinguished panel today and thank them for their testimony. Your contributions are very valuable and timely in this stage of health care reform.

There are many considerations that will need to be made when it comes to voting on a health care package, and we are here today to contemplate, together, what the options, implications and consequences may be.

As a member of this committee, my concern is that Federal employees continue to receive the same benefits that they currently receive and have earned throughout their years of service. I am very reluctant to support a health plan that will provide its beneficiaries with less coverage than they are receiving under their current plans. In fact, my original answer to the question of universal health care was to provide the rest of the country with the same benefits that Federal employees currently receive, which has proven to be a very effective, comprehensive program.

My colleagues and I are faced with many options. Many have suggested that we embrace the single-payer health care plan, while the administration's plan is primarily focused on universal coverage. Like President Clinton, I believe that the bottom line on health care coverage must be universal coverage. The question before us, of course, is what road do we take to reach this laudable goal?

For this very reason, we have invited these witnesses today, so that we may continue to ponder the potential results that the various helath care alternatives may generate.

PREPARED STATEMENT OF HON. BARBARA-ROSE COLLINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I am pleased to join you and the other distinguished members of this committee, as we examine H.R. 3600—known as "Health Security Act of 1993"—and especially its impact on the health benefits of postal service employees.

I am sure that many Federal employees—including postal employees—are interested in knowing, if this proposal will mean the total elimination of the benefits that they now receive under the Federal Employees Health Benefits Program [FEHB] which may be abolished.

Therefore, before serious dialogue can begin, it must be determined if the current postal service employees health care benefits program is broke and thus needs fixing, or maybe isn't broken and perhaps the entire country's health care program should be modeled after the Federal Health Benefits Program [FEHB].

Mr. Chairman, one thing is certain, we must ensure that no postal employee is disadvantaged under a nationalized health care program. We must examine if abolishing FEHB will ultimately result in current enrollees losing the benefits of medical care choices, and reduced health care benefits, while being forced to pay higher premiums.

Accordingly, I would like to take this opportunity to thank you and also our panel of witnesses, for the commitment to helping us resolve this most important issue.

I am confident that this committee will make every effort to address these concerns and any others that will help to make certain that the health care plan which is ultimately adopted, will be one that is absolutely the best for all Americans, including postal workers.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. THOMAS C. SAWYER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Thank you, Mr. Chairman, for your continued leadership as we seek to address our nation's health care dilemma.

This hearing is devoted to reviewing the effects of the Health Security Act on the Postal Service and its employees. Because of the agency's unique status, it has never been required to participate in the Federal Employees Health Benefits Plan. However, it has done so since its 1971 reorganization.

Under the President's legislation, the Postal Service would have the option of forming its own corporate alliance. As I understand it, corporate alliances would operate under the same rules as regional alliances, except that they would serve a limited population—the company's employees and their dependents.

As chairman of the subcommittee that has oversight responsibility for matters affecting the postal workforce, I want to ensure that postal employees continue to receive the quality of health care that they are accustomed to and deserve.

Again, thank you, Mr. Chairman. I look forward to hearing the views of our witnesses today.

CONSIDERATION OF VIEWS OF FEHBP FEE-FOR-SERVICE PLANS AND MANAGED CARE ORGANIZATIONS ON H.R. 3600, THE HEALTH SECURITY ACT OF 1993

THURSDAY, FEBRUARY 24, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON POST OFFICE AND CIVIL SERVICE,
Washington, DC.

The committee met, pursuant to call, at 10 a.m., in room 311, Cannon House Office Building, Hon. William L. Clay (chairman of the committee) presiding.

Members present: Representatives Clay, Ackerman, Norton, Wynn, Bishop, and Morella.

Mr. CLAY. The committee will come to order. This morning the committee holds its fourth hearing on H.R. 3600, the President's proposal to reform the Nation's health care system. The committee will hear today from a panel of witnesses representing the fee-for-service plans, health maintenance organizations, and other managed care organizations that operate in the Federal Employees Health Benefits Program.

Under the bill, the program would be dismantled, and Federal Employees and retirees would be enrolled in state regional health alliances. Therefore, the President's proposal could have very severe consequences for FEHB plans in general.

While several plans may be in a position to participate in the regional alliance system, many simply aren't. Besides their views on these life or death issues, today's witnesses, who represent organizations that have participated in the FEHBP for many years, have unique perspectives on the merits of the President's proposal and the operation of the FEHBP. The committee looks forward to your testimony today.

[The prepared statement of Hon. William L. Clay follows:]

PREPARED STATEMENT OF HON. WILLIAM L. CLAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

This morning, the committee holds its fourth hearing on H.R. 3600, the President's proposal to reform the nation's health care system.

The committee will hear today from a panel of witnesses representative of the fee-for-service plans, health maintenance organizations and other managed care organizations that operate in the Federal Employees Health Benefits Program [FEHBP].

Under the bill, the program would be dismantled and Federal Employees and retirees would be enrolled in State regional health alliances. Therefore, the President's proposal could have very severe consequences for FEHBP plans in general. While several plans may be in a position to participate in the regional alliance system,

many simply aren't. Besides their views on these "Life or death" issues, today's witnesses, who represent organizations that have participated in the FEHBP for many years, have unique perspectives on the merits of the President's proposal and the operation of the FEHBP.

The committee looks forward to their testimony.

Mr. CLAY. Is there any other opening statement? Mr. Bishop.

Mr. BISHOP. Thank you very much, Mr. Chairman. I want to thank the witnesses, who have joined us today to share their perspective on H.R. 3600, the Health Security Act.

Clearly, we all agree that the time for health reform is now and we cannot afford to continue to pay for a health care system that's out of control. The Health Security Act of 1993 is aimed at guaranteeing that all Americans receive health care coverage. I reviewed several other plans geared toward making health care accessible to all.

I believe that the impact of the Health Security Act or any other plan would have on the Federal Employees Health Benefits Program must be considered carefully, but I also believe that we have to offer a plan that will protect the health of our nation.

I'm especially interested in hearing the views of the witnesses on the current proposals as they relate to the Federal Employees Health Benefits Program and any recommendations that you might have on what we can do to ensure that the burden of health care reform does not fall on any one group of people and that your benefits are not reduced.

As a member of Congress and one how uses the program for my insurance coverage, I do understand how important it is for federal employees and retirees. Under the President's plan, health care for federal employees and retirees would be phased in. I would caution the administration, however, not to set us apart from the rest of the nation if we are to get our health care system back on track.

I anticipate that the hearing will be quite informative and help us to implement a health care strategy that will be of benefit to all of us in this nation.

Thank you, Mr. Chairman.

Mr. CLAY. Thank you.

Mr. BISHOP. I'd like to offer my remarks.

Mr. CLAY. Without objection, so ordered. Mrs. Morella, do you have any comments?

Mrs. MORELLA. Thank you. Just a brief opening statement, Mr. Chairman. Thank you.

Every time we have a dialogue on health benefits, whether it's the open season health benefit seminar, the carrier letters sent by the Office of Personnel Management, the reform of the Federal Employees Health Benefits Program as we've had in previous Congresses, or hearings on the proposed Health Security Act, we're reminded of how important health benefits are to our basic standard of living. In fact, a healthy body, healthy mind is true.

All our citizens deserve the opportunity to maintain good health without worrying about cost and coverage. I certainly will work toward attaining this goal, as I know this committee will.

However, the merging of the current known entity of the FEHBP into an unknown Health Security Act does have some signs of prematurity. The FEHBP currently enjoys good health. A good surgeon won't perform surgery when it isn't necessary. And at this

time the dismantling of the federal program doesn't really appear to be necessary.

It certainly seems, Mr. Chairman, that the federal alliance of over nine million participants, a cost-effective program, the model for the Health Security Act, should be left intact.

The Federal sector should be viewed as an over 5,000-employee corporation, if for no reason, retaining the FEHBP could be viewed as a standard, really, for comparison for all the state alliances.

Furthermore, it appears that putting participants of the Federal program into state alliances will result in employees at a low-cost geographical area being advantaged over those in a high-cost area. Any benefit of the locality pay would be gobbled up by health insurance premiums.

Mr. Chairman, I do look forward to hearing the ideas that are presented by our witnesses and the discussion. I thank you.

Mr. CLAY. Thank you.

This morning our witnesses will include Harry P. Cain II, senior vice president of Blue Cross and Blue Shield; Richard G. Miles, president of Government Employees Hospital Association, Inc.; John E. Ott, M.D., chief executive officer, George Washington University Health Plan, on behalf of the Group Health Association of America; and Kelbourne Ritter, senior vice president, U.S. Healthcare, on behalf of the American Managed Care and Review Association. Gentlemen, welcome to the committee. You may be seated.

Without objection, all of your statements will be entered into the record at this point. You may proceed as you so desire. Mr. Cain.

STATEMENTS OF HARRY P. CAIN II, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD; ACCOMPANIED BY RICHARD G. MILES, PRESIDENT, GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION, INC.; JOHN E. OTT, M.D., CHIEF EXECUTIVE OFFICER, GEORGE WASHINGTON UNIVERSITY HEALTH PLAN, FOR GROUP HEALTH ASSOCIATION OF AMERICA; AND KELBOURNE RITTER, SENIOR VICE PRESIDENT, U.S. HEALTHCARE, FOR THE AMERICAN MANAGED CARE AND REVIEW ASSOCIATION

Mr. CAIN. Mr. Chairman, I am pleased by the opportunity to be here. I'm here today with Mr. Alan Spielman. Alan is the officer in full charge of our FEP program.

Mr. Chairman, since you have accepted our full statement for the record, I think I can summarize our views on this subject with just three points, three issues on which we feel very strongly. First, we believe that action by this Congress to reform this country's health care financing system is essential. The current system has many serious problems that do need prompt attention. And we very much commend the President for assigning such a high priority to health care reform.

Second, we are very much opposed to the prospect of taking apart the Federal Employees Health Benefits Program. FEHBP is not only not a problem that has to be solved by this Congress, it

is one of the most successful health benefit programs in the country, however assessed. The program in our view should be preserved for itself and as a prototype that other very large employers ought to consider.

We do understand that the Congress would have an image problem in preserving the FEHBP if health care reform does not make adequate health programs available to all Americans who do not now have them. In particular, the idea of forcing nearly all Americans to get their health care through regional health alliances, while exempting the Congress and all other federal employees from such a requirement, might be hard for the general public to swallow. Fortunately, we don't believe you'll have that problem, which takes me to point 3.

In our view, the most serious flaw in the Clinton proposal is its reliance on these mandatory regional health alliances, a very complicated and as yet totally untried concept.

Fortunately, all of the other aims of the health care proposal can be achieved without such regional health alliances. And many members of this Congress are coming to such a conclusion.

Therefore, we understand that the concept of these RHAs, regional health alliances, is in serious trouble on Capitol Hill, as it should be. And it isn't apt to wind up in the final bill. If that happens, then the future of the FEHBP can be considered simply in terms of assuring its consistency with health care reform generally.

That summarizes the essence of our view on this matter, Mr. Chairman.

[The prepared statement of Mr. Cain follows:]

PREPARED STATEMENT OF HARRY P. CAIN II, SENIOR VICE PRESIDENT, BLUE CROSS/BLUE SHIELD

Mr. Chairman, and Members of the Committee, I am Harry Cain, Senior Vice President of the Blue Cross and Blue Shield Association. I appreciate the opportunity to appear before you to present the Association's views on H.R. 3600, The Health Security Act of 1993, as it would affect the Federal Employees Health Benefits Program [FEHBP]. The Association serves as the administering agent for the 67 Blue Cross and Blue Shield Plans throughout the nation that underwrite the Government-wide Service Benefit Plan under the FEHBP.

We have been extensively involved in providing health benefits protection to federal employees and retirees for over 34 years. Nearly 1.8 million federal employees and retirees are now enrolled in the Blue Cross and Blue Shield Service Benefit Plan, representing coverage of about 3.1 million individuals. In addition, many Blue Cross and Blue Shield Plans have HMOs that participate in the FEHBP under separate contracts with the U.S. Office of Personnel Management. These HMOs enroll approximately another 135,000 federal workers and retirees.

THE GOAL OF REFORM AND THE IRONY OF SUCCESS

The Blue Cross and Blue Shield Association applauds the President for moving health care to the top of the national agenda. H.R. 3600, the President's proposal, is a comprehensive design for providing universal coverage for all Americans, reforming the insurance marketplace and emphasizing managed care as an effective cost-containment strategy. There are many features in H.R. 3600 with which we agree.

In particular, we agree with its emphasis on health insurance reform, on setting requirements for accountable health plans, on using the competitive dynamics of the marketplace, and on seeking ways to make such coverage available to everyone.

But—the Association strongly disagrees with the proposal to abolish the FEHBP. The FEHBP has successfully restrained premium costs while providing superior coverage for over 9 million people. It is the nation's largest existing model of unrestricted access, consumer choice, competition and managed care. By any measure, the FEHBP is a national success.

The Director of the Office of Personnel Management stated in testimony before this Committee that, "The FEHBP is a superior program because it exhibits many of the principles the President has identified as the foundation of the Health Security Act". The First Lady, in her testimony, before the Senate Finance Committee, referred to the FEHBP as the "model" that the Administration has looked to in fashioning elements of its reform plan. The President, in his State of the Union address, referred to the FEHBP as a plan that provides "terrific health care benefits at reasonable cost".

In view of these positive comments and the program's successful track record, there is a certain irony in the proposal to dismantle the FEHBP. The proposal is all the more curious when one considers that large private-sector employers (over 5,000 employees) would be permitted to continue their health plans; other federal health programs such as the Veterans Affairs, CHAMPUS, and the Indian Health Service would not be dismantled; and postal employees, along among federal employees, would have the option of jointing a "corporate" alliance.

One of the most disturbing aspects of the proposal is its lack of recognition of the factors that have created FEHBP's current success. The program did go through some very difficult periods. We nearly pulled out of it ourselves, in the early '80s, even with the very large market share we held at that time. Over the last ten years, however, the program has demonstrated steady improvements, annual modifications, to the point where it now demonstrates how effectively the managed competition idea can work—wide consumer choices, comprehensive benefits, excellent service, no exclusions, reasonable costs, etc. But that successful evolution was not a simple, easy, quick accomplishment. H.R. 3600 does not appear to value the experience, both because it proposes to throw it away, and because it assumes that similar programs can be rather easily created, all over the country.

Administration spokespersons have advanced several arguments for abolishing FEHBP. In testimony before this Committee, the reasons given or suggested included: the FEHBP operates much like the regional health alliances the President is proposing, so federal employees should not experience a significant change when they move into the new system; federal employees should fare well because of higher contribution levels and supplemental packages to compensate for lower benefit values; dismantling the FEHBP would protect federal employees from future assaults on their health benefits; and, would avoid the perception that privileges are accorded to bureaucrats and Members of Congress that are not available to ordinary citizens.

Frankly, these reasons are not compelling. In fact, most observers agree that the only real argument for abolishing the FEHBP is a political one; and "equal treatment" argument that stems from what many see as a serious design flaw in the President's proposal. H.R. 3600 relies heavily on mandatory regional alliances as the centerpiece of reform. Under the President's proposal, virtually all employers and individuals would be forced to obtain health care coverage through the mandatory alliance scheme. Because of this design feature, the Administration apparently concluded that it would be politically unacceptable to force most Americans to rearrange the way they obtain health insurance while leaving the successful FEHBP—which covers Members of Congress and high government officials—intact.

MANDATORY ALLIANCES ARE A PROBLEM, NOT A SOLUTION

There are serious practical problems associated with a strategy that depends on mandatory Health Alliances. With respect to the FEHBP, establishing new entities for collecting premiums, enrolling individuals in the health plan of their choice, notifying health plans of changes in coverage, and distributing dollars to plans would simply be reinventing a rather complex engine. The unnecessary dislocation of 9 million people would be enormous in terms of costs and confusion.

With respect to all Americans, the responsibilities placed on Health Alliances would be overwhelming. As the recent CBO report noted, these new entities "would combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems, and coordinators of the flow of information and money * * *". Indeed, we commend to this Committee's attention the last chapter of the CBO Report on H.R. 3600, entitled "Other Considerations". As the CBO notes there, "the potential for unforeseen consequences * * * would be significant".

The Blue Cross and Blue Shield Association believes requiring all health plans to compete on the basis of quality and price will drive down costs as consumers choose a basic benefits package based on value. We maintain that a strategy that relies on Health Alliances covering everyone is not necessary and will only delay reforms that are urgently needed.

As we, and others, continue to illuminate the practical problems associated with mandatory regional alliances, we are heartened by a growing receptivity to the logic of our arguments in the Congress and in the Administration. Senior Administration spokespersons are publicly expressing a willingness to consider more exceptions to the alliances. Several of the Committees tasked with reviewing the overall structure of health reform are expressing a disinclination to consider seriously those proposals, such as alliances, which may not work and, in fact, have a high probability of failure. In short, the proposal to establish mandatory health alliances consisting of all but the largest private employers and the few politically chosen exceptions now in H.R. 3600 is not likely to survive the legislative process. That certainly is our hope—and if the alliance concept is defeated, the question of FEHBP's future would automatically be recast.

In addition to the practical problems with mandatory alliances, another factor is emerging that should diminish the political pressure to dismantle the FEHBP. We refer to the concerns expressed by other public-sector employers about the provisions in H.R. 3600 that would force state and local employees into mandatory alliances. We note, in particular, New York Governor Cuomo's strong criticism of the adverse effects on state employees if the President's proposal were to prevail and his pledge to work actively to maintain the New York health plan. California officials who are responsible for operating the highly successful CALPERS health plan also have publicly expressed concern about dismantling that state's plan. As other public officials examine the details of H.R. 3600, concerns about the inequitable treatment of public employees compared to the employees of large private companies, in all likelihood, will grow.

A FRAMEWORK FOR EVALUATION—THE BLUE CROSS AND BLUE SHIELD PERSPECTIVE

The Blue Cross and Blue Shield Association believes that a compelling case can be made for retaining—and strengthening—the FEHBP because it is fully consistent with the broad aims of H.R. 3600. Clearly, such an approach would meet the criterion that has been stated repeatedly by the President and other Administration officials of "building on what works today."

The FEHBP is one of the nation's best examples of an existing program that can achieve all of the goals set out by the Administration in H.R. 3600 and it provides a framework for attaining additional improvements. To illustrate, we would note how the FEHBP more than meets the six principles President Clinton has set forth to guide the reform effort and how the program could be further strengthened:

1. *Security*—FEHBP has guaranteed access and coverage for the entire eligible population, nationwide, regardless of health status or age. There are no exclusionary waiting periods or limitations on pre-existing conditions.

2. *Comprehensive Benefits*—Most FEHBP plans compare favorably to the proposed benefit package outlined in H.R. 3600. Because of the very intricate and complex way in which H.R. 3600 would affect all sectors of health care, it is difficult to make accurate apples-to-apples comparisons of benefits, premiums, quality, and access between the actual offerings in the FEHBP and the proposed offerings in H.R. 3600. But, there are some obvious areas where FEHBP benefits are generally superior, such as inpatient hospital coverage. Retaining FEHBP intact would obviate the need for supplemental benefit packages which are proposed, but unspecified, in H.R. 3600. If the Congress should enact a standard benefit package as proposed in H.R. 3600, the existing FEHBP could easily accommodate any benefit design. While we do not believe a single standardized benefit design will be workable or desirable, a limited number of standardized benefit designs will allow consumers to compare products easily.

3. *Controlling health care costs*—For 1994, the FEHBP average overall premium increase is only 3 percent over 1993, even with several benefit improvements. FEHBP has controlled costs better than most private sector heath plans for four consecutive years. During this time, premium increases for all FEHBP plans averaged only 6.5 percent per year. This success did not happen overnight. It is the result of many years of substantial effort. For example, starting in 1985, we instituted a program of individual case management that provides cost-effective alternatives to long-term hospitalization. In 1986, we initiated our first PPO designs and by 1993 our nationwide PPOs include over 3,000 hospitals and 300,000 physicians. In 1987, we initiated a nationwide mail order prescription drug program that provides maintenance drugs at significant savings to both the program and subscribers, and in 1993 we introduced an innovative managed retail pharmacy program. For 1994, we were about to add a preferred dental network that provides out-of-pocket savings at no cost to the program. Clearly, the FEHBP has become a national model with regard to controlling health care costs, while offering excellent benefits and services.

4. *Quality*—The health plans participating in the FEHBP have learned to focus on quality of care and quality of service—because dissatisfied subscribers can and do "vote with their feet". They choose another plan. We now routinely survey our subscribers to determine their levels of satisfaction, and take corrective action when problems appear.

5. *Choice*—More than 300 plans will be offered to many FEHBP enrollees in 1994. Every subscriber has at least as many, and perhaps many more, choices than would be provided under H.R. 3600. And the FEHBP offers an opportunity to move forward now in areas contemplated by the President's proposal. For example, H.R. 3600 would require that point-of-service plans be widely available. The Blue Cross and Blue Shield Service Benefit Plan is pursuing a proposal with the Office of Personnel Management to offer a pilot point-of-service product because we think we must continue to make improvements and seek innovation solutions. We have not received OPM's approval to proceed yet, but we strongly feel that the FEHBP must not stagnate, or retrogress, during the reform debate. We would hope that the Committee shares this view.

6. *Simplicity*—To achieve simplicity in administration—while offering to large populations many health plan choices, assuring quality, containing costs, and evaluating progress—is not easy. At this point, the administrative machinery necessary to operate FEHBP entails only simple payroll transactions by employing agencies, with centralized administration and guidance by the U.S. Office of Personnel Management, while the Treasury performs its customary investment and disbursing functions. The administrative challanges of regional alliances, handling thousands of small employers, and having to coordinate with all the other alliances to cope with subscribers who become ill while traveling "out of area" will really put the notion of simplicity to the test.

Thus, not only is there no rational argument for abolishing the FEHBP, but judged by the very yardsticks that the President has set forth to measure reform, there is every reason to maintain the program intact.

We do understand the political problem the Congress would have if it retained FEHBP but offered nothing comparable for the large numbers of Americans who are not so fortunate. The issue then is how to reform those aspects of our health care system which are not working as well as the FEHBP. And we do have a number of policy proposals to make in that regard. But as you might guess, our reform proposals do not include abolishing the FEHBP. We believe that the FEHBP, as the world's largest working model of managed competition, should be retained and enhanced; not just for the benefit of federal subscribers, but for the contribution it can make toward reaching our national objectives.

The Blue Cross and Blue Shield Association commends the Committee for convening these hearings and examining this very important issue. I will be happy to respond to your questions.

Mr. CLAY. Thank you.

Mr. Miles.

Mr. MILES. Mr. Chairman and members of the committee, I'm Richard Miles, President of the Government Employees Hospital Association. Thank you for allowing me the opportunity to appear before you today and share with you some of the concerns of my organization and our membership about the Health Security Act. I will submit a detailed testimony for the record and would like to take just a few minutes to summarize my written statement.

Like many of those who have testified previously, we support the President's efforts to reform the Nation's health care system. However, we strongly believe that the Federal Employees Health Benefits Program should be retained and not disbanded.

Our members are concerned about a decrease in benefits, an increase in premium costs, and restrictions in their freedoms of selecting medical providers.

We firmly believe that GEHA is a model of what is best about America's health insurance system. We strive to live up to our mission statement, and that is we will provide Federal employees and retirees with high-quality financial protection from the medical

costs of illness at a fair price with dedication to excellence in service.

President Clinton's Health Security Act calls for disbanding the program and requiring Federal employees to purchase their health insurance through new, untested regional and seemingly State-run alliances. This poses significant problems for our association, its members, Federal employees and retirees.

This legislation jeopardizes our business and leaves our membership at risk. The bottom line is that the Federal Employees Health Benefits Program works, and it works well.

In conclusion, we would urge you to use the Federal Employees Health Benefits Program as a model for reform, rather than destroy what is working well, we would encourage you to reproduce it for the private sector.

We also recommend that you allow the Federal Employees Health Benefits Program to become its own alliance. We believe that GEHA as a member of the FEHB has served its membership in the Federal Government well for the past 34 years. And we look forward to participating as part of the future solution in health care financing.

Thank you again for the opportunity to testify.

[The prepared statement of Mr. Miles follows:]

PREPARED STATEMENT OF RICHARD G. MILES, PRESIDENT, GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION, INC.

Mr. Chairman and members of the Committee, I am Richard Miles, President of the Government Employee Hospital Association. GEHA is a non-profit association of federal employees and is headquartered in Kansas City, Missouri and serves almost 300,000 federal employees nationwide.

We at GEHA recognize the need to reform parts of the health care system based on the six principles that President Clinton enunciated when he presented his plans to the American people. In fact, we have been operating on these principles for the past 55 years. We applaud both the President and you for taking on this difficult task.

In reshaping the American health care system we hope you will analyze what parts of the health care system work and which parts are in need of reform. As President Clinton himself said when he presented his proposal last September . . . "As we undertake this journey for change, we clearly must preserve what's right with our health care system . . ."

We firmly believe that GEHA is a model of what is best about America's health care insurance system. We try to live up to our mission statement—"GEHA will provide federal employees and retirees with high quality financial protection from the medical costs of illness at a fair price with dedication to excellence in service." It is a mission we take seriously. GEHA represents a model program of the free market system, operating more effectively and efficiently than equivalent private sector plans. The secret of our success and that of the Federal Employee Health Benefits Plan is that we promote consumer choice and a competitive insurance market.

President Clinton's Health Security Act calls for disbanding the FEHB program and requiring federal employees to purchase their health insurance through new, untested, regional and seemingly state-run alliances but with federal oversight. This change poses significant problems for GEHA, its members, federal employees and retirees. To be blunt, it puts us out of business and puts our membership at risk.

It is ironic that the major reason for dismantling the FEHB—and it is a political one—is that it would be "unfair" for federal employees to get a special "deal" with better coverage while the rest of America gets second-class coverage. The question should be turned around. If federal employees are getting good health care financing—and we believe they are—then shouldn't that be a model for national health care? Shouldn't the system be encompassing enough that federal employees benefit programs could be among the so-called "choices" for all Americans? Shouldn't these programs providing quality service for nine million Americans be expanded to allow others to participate? We believe so.

That is why we oppose disbanding FEHB. It should instead be retained in the alliance system and used as a model for reform. Let me quickly tell you why FEHB works well and then why GEHA works extremely well and fits perfectly within the Clinton principles.

FEHB Works. The FEHB program works well. It provides comprehensive coverage to over nine million persons. It includes complete freedom of choice of health plans without fear of being denied coverage due to pre-existing conditions. It provides portability among federal jobs and after retirement. It provides coverage world-wide and operates with relatively low administrative expenses. In fact, from 1980 to 1992 the FEHB program has had a compound annual premium growth rate of less than 9% whereas the private sector has had growth rates of about 12%. In 1993, the rate increase for the program was about 3% and GEHA had no rate increase. The program includes price competition which causes plans to have strong cost controls. The FEHB program has worked so well that it is now recognized as a model for managed capability of health care reform in general.

GEHA Meets the Clinton Six Principles. Even within the excellent FEHB program, we believe that GEHA stands out and meets the Clinton health care principles.

Let me quickly tell you how GEHA meet them.

Clinton Principle One: Guarantee of comprehensive benefits for all American citizens and legal residents, regardless of health or employment status. Health coverage continues with no lifetime limits or without interruption if Americans lose or change jobs, move from one area of the country to another, become ill or confront a family crisis.

The FEHB plan provides:

Comprehensive major medical coverage that includes well-baby care along with routine examinations and physicals, mental health, prescription drugs, basic preventative dental care, hospice care.

Portability among federal jobs and after retirement.

Choice of what combination of services and price is best for members and their families.

No exclusion for pre-existing conditions.

Clinton Principle Two: Effective steps to control rising health care cost for consumers, business and our nation.

FEHB program operates on price competition which automatically ensures that plans such as GEHA have strong cost controls. The FEHB program has been cited for its low administrative cost overseeing the health care for 9 million federal employees.

GEHA, through its Cost Utilization Department, assists the claims area in identifying reasonable and customary fees, medically necessary services, investigative or cosmetic procedures and irregularities in billing.

GEHA through its affiliation with Affordable/Health Care Compare offers its members a quality comprehensive network of providers who agree to prenegotiate discounted rates.

GEHA recognizes the critical need for responsible managed care programs. Successful managed care administration reduces the need to increase premiums by making the most effective use of claim benefit dollars.

GEHA is committed to help curb the inflationary spiral of medical care costs. Recognizing the need to address the health care cost challenge we established specific programs which address this national problem.

Catastrophic Case Management is one of the programs GEHA has instituted to control medical costs while providing quality health care to our members. The program offers support for members struggling with a catastrophic situation by providing a nurse who specializes in catastrophic case management. The nurse coordinates the medical care of a patient, acting as a liaison among the medical care providers, the family and the patient. The nurse can effectively develop alternative treatment plans which fully meet the individual patient's medical needs while achieving cost-effectiveness. Catastrophic Case Management offers a personalized program that assures quality care in a cost-effective setting.

GEHA has been cited as having the lowest administrative costs of all the fee for service plans (source: GAO Report on Administrative Expenses, Congressional Hearing, March 11, 1992).

Clinton Principle Three: Improvements in the Quality of Care

GEHA is not a mere third party payor of claims. GEHA is an active participant in the health care delivery system. Careful control of claim payments through responsible design and managed care programs ensure the GEHA's members receive the finest medical treatment at a fair price.

GEHA is flexible and responsive to the needs of members, utilizing advanced technology continually upgrading the quality of health care.

Clinton Principle Four: Increased choice for consumers.

GEHA is based on the freedom of choice. Members of GEHA have the freedom to choose any doctor, surgeon, chiropractor or any hospital. Members also have the freedom to purchase any drugs and medicines by mail or at their local pharmacy.

Clinton Principle Five: Reductions in paperwork and a simplified system.

GEHA is aggressively implementing its plans for Electronic Data Interchange (EDI) or more commonly known as electronic filing of claims. GEHA is a "Beta" test site or pilot for the National Electronic Information Corps' (NEJC) software for implementing the ANSI 837 standards.

GEHA is currently accepting Medicare Crossover claims electronically and virtually all of our prescription drug claims are submitted electronically.

GEHA has no required standardized claims forms and we accept all versions of hospital claim forms (UB82) and physician claim forms (HCFA 1500).

GEHA has an optional paperless enrollment process which is used by some payroll offices and we are participating with OPM on a task force to expand this capability government wide.

Clinton Principle Six: Making everyone responsible for health care.

Like the Clinton proposal, GEHA recognizes that consumers of health care will more responsibly use the program through a reasonable system of co-payments and deducibles. By providing excellent preventive care, consumers now became responsible in getting the preventive care they need before a small health problem becomes a big one.

Conclusion: We urge you to keep FEHB and GEHA in place. Forcing nine million people out of the FEHB program and into untested alliances makes no sense when FEHB not only is successful but is a working laboratory for change and reform. There's a saying we all know, "If it ain't broke, don't fix it." In Missouri we have another saying, "Show me!" We think we have shown that we can be an integral part of reform health care system and that America can build on our strengths. We look forward to working with you as the process goes forward.

Mr. Chairman, thank you again for the opportunity to testify.

Mr. CLAY. Thank you.

Mr. Ritter.

Mr. RITTER. Mr. Chairman and members of the committee, my name is Kel Ritter, and I am the Senior Vice President for Federal and State Government Accounts for U.S. Healthcare, which is the largest HMO in the Northeast, with over 1.6 million members. Of this total, over 10 percent are FEHBP members and their families.

I am here today on behalf of the American Managed Care and Review Association in my capacity as Chair of the AMCRA FEHBP Task Force. AMCRA is a national trade association representing over 500 managed care organizations, including health maintenance organizations, preferred provider organizations, and utilization review organizations. Together our organizations provide managed care coverage to over 75 million Americans, which include FEHBP employees.

We are pleased to present before this committee AMCRA's views on President Clinton's Health Security Act, particularly the President's proposal to integrated FEHBP enrollees into the regional alliances and to repeal the current federal employees' health care program as we know it.

AMCRA believes that the time for health reform has come, and we is on record as supporters of managed competition as a viable reform mechanism. However, we are also concerned about several provisions contained in President Clinton's Health Security Act. Of particular concern is the requirement that forces everybody to obtain health coverage through a regional or corporate health alliance.

AMCRA does not support the notion that everyone should be forced to obtain coverage through these alliances. AMCRA members have grown and expanded in the competition marketplace because they offer cost-effective, high-quality health care. Health alliances will stifle the innovation and competitive pricing that currently exits, if not in the short run, definitely in the long run.

However, if Congress ultimately includes health alliances in legislation, AMCRA believes that such alliances must be voluntary, nonregulatory, limited to individuals and employers of 100 or fewer employees, and required to offer all accredited plans.

Indeed, before Congress decides to make such alliances mandatory, it should consider the biofeedback coming from the State of California's voluntary alliances, which were established in July 1993 to reform the small group market. Currently approximately 25 percent of the employers now purchasing health benefits for their employees and dependents through the alliance had never purchased health insurance for their employees before this program began.

I'd like to turn now to the specific issue of the President's plan as it relates to FEHBP. We believe it's important to acknowledge that the FEHBP as administered by the Office of Personnel Management has over the course of the 34 years of its existence worked well for nearly 9 million Government employees, retirees, and their dependents enrolled at any given time.

OPM has gained tremendous experience in operating a national and uniform managed competition system. And it annually contracts with more than 300 insurance plans and managed care organizations, including many of the AMCRA members, and it handles inquiries of nearly 1.9 million FEHBP members.

Under FEHBP, OPM currently must ensure that each Federal employee, retiree, and dependent receives a basic set of health plans, health care benefits. There is a uniform set of criteria that particular plans must meet. Indeed, recent years have shown the effectiveness of FEHBP from both a cost and benefit perspective.

For instance, the overall premium increase in 1993 for FEHBP was 3 percent. That represents the fourth consecutive year that FEHBP employees and annuitants have looked forward to better benefits and low-rate increases in their health insurance. Indeed, approximately 40 percent of these employees are paying less in 1994 for insurance than they were in 1993.

In addition to proven cost savings, the Federal employees also have choice. They may choose among a variety of plans, ranging from quality HMO's to fee-for-service to point of service. No preexisting condition exclusion or other policy language bars portability from one plan to another during the annual open season. And because of the annual open season, participating plans compete based on cost and quality to enroll the most employees.

The President's plan would repeal to a great extent a system that has taken years to develop. It's a system that works well and low administrative costs. Yet, according to the President's plan, on July 1, 1998, FEHBP as we currently know it would no longer exist. No later than December 31 of 1997 the Health Security Act would force most Federal workers, retirees, and dependents to enroll in

plans selected by regional health alliances, thereby completely disregarding the current, proven, and tested system, and replacing it with one that is untried, untested, and fraught with uncertainty.

The Health Security Act would also eliminate uniformity from State to State for Federal employees and each State would be permitted to impose other requirements so long as they are consistent with the act.

Therefore, each health plan, while mandated to provide a basic set of health care benefits, still would need to pursue State by State certification and alliance by alliance contracts in order to sell its product. This is costly and inefficient and will result in reduced choice for Federal employees.

There are a number of additional issues that should be taken into consideration before even considering incorporation of the FEHBP program into national health reform. For instance, what role would OPM play with respect to health alliances? Will it be treated like other employers? What will its continuing relationship be with employees? How will the supplemental package offered by OPM be coordinated with the benefits being received through health alliances?

In addition, currently under FEHBP once a plan is certified by OPM to participate, it may continue to participate in the open enrollment process unless OPM wants to terminate the plan's participation for cause.

Will the President's proposal permit States or health alliances to terminate a plan's participation without cause or without due rights?

The FEHBP has been held up as a model of choice and savings that can be accomplished through managed competition. It's ironic that the Health Security Act, supposedly premised as marketplace managed competition, would dismantle FEHBP, CalPers, and other proven mechanisms and replace them with new, untested bureaucracies that can easily be politicized.

We should preserve and build upon what is working in our current system, such as FEHBP, rather than pursuing change merely for the sake of change. At the very least, it would be wise to wait and see how a new system created by health reform works before taking nearly 9 million enrollees from a cost-efficient system and placing them into an unknown system, especially when a mistake would impact dreadfully on the Federal budget.

Mr. Chairman, members of the committee, I appreciate the opportunity you have afforded me to present the views of AMCRA on this important issue. Thank you.

[The prepared statement of Mr. Ritter follows:]

PREPARED STATEMENT OF KELBOURNE RITTER, SENIOR VICE PRESIDENT, U.S. HEALTHCARE, FOR THE AMERICAN MANAGED CARE AND REVIEW ASSOCIATION

Mr. Chairman and Members of the committee, my name is Kelbourne Ritter. I am the Senior Vice President for Federal and State Government accounts for U.S. Healthcare, the largest HMO in the northeast with over 1.6 million members. Of this total, over ten percent are FEHBP members and their families. I am here today on behalf of the American Managed Care & Review Association (AMCRA) in my capacity as Chair of the AMCRA FEHBP Task Force. AMCRA is a national trade association representing over 500 managed care organizations, including Health Maintenance Organizations (HMOs), Independent Practice Associations (IPAs), Preferred

Provider Organizations (PPOs), and Utilization Review Organizations (UROs). Together, our member organizations provide managed health care coverage to over 75 million Americans, including FEHBP enrollees.

We are pleased to present before this Committee AMCRA's views on President Clinton's "Health Security Act", particularly, the President's proposal to integrate FEHBP enrollees into the regional alliances and to repeal the current Federal Employees Health Benefits Program, as we know it.

AMCRA believes that the time for health reform has come and is on record as a supporter of the principles of managed competition as the viable reform mechanism. However, AMCRA is concerned about several provisions contained in President Clinton's Health Security Act. Of particular concern is the requirement that forces everyone to obtain health coverage through a regional or corporate health alliance. AMCRA does not support the notion that everyone should be forced to obtain coverage through health alliances. AMCRA member organizations have grown and expanded in the competitive marketplace because they offer cost effective, high quality health care. Health alliances will stifle the innovation and competitive pricing that currently exists, if not in the short run, then at least in the long run. However, if Congress ultimately includes health alliances in legislation, AMCRA believes that such alliances must be: 1. Voluntary; 2. Non-regulatory; 3. Limited to individuals and employers of 100 or fewer employees, and 4. Required to offer all accredited plans.

Indeed, before Congress decides to make such alliances mandatory, it should consider the "biofeedback" coming from the state of California's voluntary alliance established in July 1993 to reform the small group market. Currently, approximately 25 percent of the employers now purchasing health benefits for their employees and dependents through the alliance had never purchased health insurance for their employees before this program began. Perhaps we should first give the marketplace a chance to correct itself through voluntary alliances before stifling it with mandatory enrollment.

Now, I would like to turn to the specific issue of the President's plan as it relates to proposed changes in FEHBP. We believe that it is important to acknowledge that the FEHBP, as administered by the Office of Personnel Management (OPM) has, over the course of its 34 years of existence, worked well for the nearly 9 million government workers, retirees and their dependents enrolled at any given time. OPM has gained tremendous experience in operating a national and uniform "managed competition system." OPM annually contracts with more than 300 insurance plans and managed care organizations, including many of AMCRA's members, and it handles the inquiries of the nearly 1.9 million retirees currently covered by FEHBP.

Under FEHBP, OPM currently must ensure that each federal employee, retiree, or dependent receives a basic set of health care benefits. There is a uniform set of certification criteria that participating plans must meet. Indeed, recent years have shown the effectiveness of FEHBP from both a cost and benefits perspective. For instance, the overall premium increase in 1994 for FEHBP was 3 percent. This represents the "fourth consecutive year that FEHBP employees and annuitants can look forward to better benefits and low rate increases in their health insurance."[1] Indeed, more than 40 percent of FEHBP members 1994 premiums are lower than their 1993 premiums.[2]

In addition to proven cost savings, federal employees also have choice. They may choose among a variety of plans, ranging from quality HMOs, to fee-for-service, to Point of Service (POS). No pre-existing condition exclusions, or other policy language bars portability from one plan to another during the annual open season—and because of the annual open season, participating plans compete, based on cost and quality, to enroll the most employees.

The President's plan would repeal, to a great extent, a system that has taken years to develop and to refine. It is a system that works well and has low administrative costs. Yet according to the President's plan, on January 1, 1998 FEHBP as we currently know it, would no longer exist. No later than December 31, 1997, the Health Security Act would force most federal workers, retirees and their dependents to enroll into plans selected by the regional health alliances, thereby completely disregarding the current, proven and tested system, and replacing it with one that is untried, untested and fraught with uncertainty.

The President's proposal may also increase the cost of health care coverage for federal employees. For example, under the proposed Act, employers contribute at least 80 percent of the average premium for an area, including Medicaid costs.

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[1] Statement of James B. King, OPM Director, quoted in, "Clinton Medical Proposal Worries Those in Plan that was a Model", Washington Post, Stephen Barr, September 24, 1993.

[2] *Id.*

Cross-subsidizing Medicaid may be a minor cost item compared to the elimination of the restraint on costs caused by removing employers from any role in selecting cost-effective plans for their employees.

The Health Security Act would also eliminate uniformity from state-to-state for federal employees, and each state would be permitted to impose other requirements so long as they are consistent with the Act. Therefore, each health plan, while mandated to provide a basic set of health care benefits, still would need to pursue state-by-state certification, and alliance-by-alliance contracts, in order to sell its product. This is costly and inefficient, and will result in reduced choices for federal employees.

One nuance of some importance with respect to a possible transition from FEHBP to health alliances, is that the Health Security Act would set-aside a contingency fund to cover outstanding FEHBP claims. OPM would decide when the monies in this fund should be disbursed. OPM would disburse any remaining funds between the Government and former FEHBP "participants." As currently drafted, it is ambiguous who is being referred to as a "participant." It is essential that such transitional disbursement be articulated clearly so that the rights of the parties are understood. Otherwise, one may have a windfall at the expense of other FEHBP participants.

There are a number of additional issues that should be taken into consideration before even considering incorporation of the FEHBP program into national health reform. For instance, what role will OPM play with respect to health alliances? Will it be treated like any other employer? What will be its continuing relationship with its enrollees? How will the supplemental package offered by OPM be coordinated with the benefits being received through health alliances? In addition, currently under FEHBP, once a plan is certified by OPM to participate, it may continue to participate in the open enrollment process unless OPM wants to terminate the plan's participation for cause. Will the President's proposal permit states or health alliances to terminate a plan's participation without cause or without due process rights?

The FEHBP has been held up as a model of the choice and savings that can be accomplished through managed competition. It is ironic that the Health Security Act, supposedly premised as marketplace managed competition, would dismantle FEHBP, CalPers and other proven mechanisms and replace them with new, untested bureaucracies that can easily be politicized. We should preserve and build upon what is working in our current system, such as FEHBP, rather than pursuing change merely for the sake of change. At the very least it would be wise to wait and see how a new system created by health reform works, before taking nearly 9 million enrollees from a cost-efficient system and placing them into an unknown system, especially when a mistake will impact dreadfully on the federal budget.

Mr. Chairman, members of the Committee, I appreciate the opportunity you have afforded me to present the views of AMCRA on this important issue. I would be happy to respond to any questions that you or members of the Committee may have.

Ms. NORTON [presiding]. Thank you very much, Mr. Ritter.

Has Dr. Ott come yet? All right. We will proceed, then. You recognize, of course, that one of the problems presented by not dismantling FEHBP would be the appearance of some special preference for Federal employees, not to mention Members of Congress.

Do you have suggestions as to how FEHBP might, consistent with what might be happening to everybody else, remain intact? How is Congress to justify treating its employees, who after all, are spread throughout the country, located in every city of any size, in this special way or how would you suggest that we do so?

Excuse me. Is this Dr. Ott? Perhaps we can hear from Dr. Ott before we proceed with any questions, then. Dr. Ott, you are right here in the center. Dr. Ott, if you would like to proceed to summarize your testimony, we will allow that before we go to question the entire panel.

Dr. OTT. Thank you. I apologize for being late.

Mr. Chairman and members of the committee, I appreciate the opportunity to testify on behalf of Group Health Association of

America concerning the Federal Employees Health Benefits Program.

I am Dr. Ott, CEO of the George Washington University Health Plan. The health plan is a mixed model HMO which serves Federal employees in the Washington area and has for the past 17 years. The organization I represent includes 350 health maintenance organizations with 33 million members, who account for approximately 75 percent of the total HMO enrollment. We have submitted a more detailed paper for your consideration, but in the interest of time, I'll try to summarize.

The Federal Employees Health Benefits Program represents an important market for many HMO's. About 300 HMO's currently participate in the program, and the enrollment growth of Federal employees has increased from about 4 percent in the early 1970's to roughly 30 percent of all Federal employees today.

GHAA believes that HMO participation in the Federal employment program has been beneficial to both employees and to the Federal Government. In recent years premium increases under FEHBP have been lower than those in the private sector. And an important factor in this achievement has been significant HMO involvement, combined with the introduction of managed care features into many of the more traditional indemnity packages.

HMO's do provide a comprehensive benefit package for a fixed monthly premium. The services provided are listed in your paper.

Not only are HMO's noted for providing a comprehensive set of benefits, their cost sharing is limited to enhance access and to make out-of-pocket costs predictable. Copayments are nominal, and coinsurance and deductibles are generally not used under traditional HMO coverage.

The emphasis on HMO's and other managed care options in the health care reform debate is both exciting and challenging to our industry. We look forward to playing an active role with you as you consider these issues.

We do believe that the FEHBP has been highly successful, and it's very important that we retain the accomplishments and stability that have been characterized in this program. Both the program's strengths and some of its weaknesses can serve as an important foundation in this.

We applaud the President for his leadership in moving health care reform to the center stage and emphasizing the need for universal coverage. We share the President's broad goals of assuring access for all Americans to comprehensive benefits, giving our citizens piece of mind by prohibiting waiting periods and preexisting condition exclusions, determining that all plans should be accountable for the quality of care and the service they provide, and protecting the right of all consumers to choose the plan that best meets their needs.

We believe the current program does work well. Changes in benefit structures or other administrative details need to be made in order to be consistent with other changes in health care reform legislation. We have not completed our analysis of the provision of the administration's proposal as they affect FEHBP. However, we can share with you several issues that have been identified in our preliminary review.

Repeal of the FEHBP program within a short timeframe does not permit the new system of alliances to work out the bugs before Federal employees are included, while arguments can be made for ultimate repeal of FEHBP or its continued retention in a status comparable to that of a corporate alliance or in some other form. It may be desirable, however, to consider delaying these changes beyond 1997. The program already meets many of the challenges of health care reform.

Since it will take time to develop a well-coordinated operational regional alliance, the FEHBP program would be better served if the decision to enroll Federal employees in the alliances was delayed until the fully operating alliances can be fairly evaluated. It is expected that many other large employers, who have the option of opting out of the system, will take a similar approach.

Speaking from a personal point of view now and not from the standpoint of GHAA, we do not believe there is a logical reason for mandatory health alliances. While the goal of the alliances is laudable, they can be accomplished by law and regulatory changes without expense of bureaucracy, which would add 2 percent to the cost of health insurance.

I believe there may be a role for voluntary purchasing alliances to place individuals or small groups who encounter difficulty enrolling in the system. I would propose the system function like a large high-risk auto insurance pool so other patients could be assigned in proportion to the size of the plan, which would spread the risk in an equitable manner to all plans. It would differ from a high-risk auto insurance pool in that the patient would be entitled to the full-coverage package and all of the other regulatory benefits available to other groups.

The most compelling reason for caution in including the FEHBP program in regional alliances is a lack of timely and accurate enrollment information. Unfortunately, a solution to this problem is not readily available.

We currently have great difficulty confirming the employees who have elected enrollment, and we have difficulty receiving payment for the patients that we know are enrolled. As you know, there is no central recordkeeping on enrollments and disenrollments, and payments frequently are not consistent with plan enrollment records.

Marketing to Federal employees will also require coordination to ensure that all agencies and employees receive needed information. GHAA has raised concerns about the nature of marketing materials provided to Federal employees under the present program.

Standardization of Federal brochure language has made consumer differentiation among HMO's difficult in terms of their service protocols, health center locations, and provider networks. A shorter length of comprehensive plan brochures in comparison to those of fee-for-service plans has also been of concern.

We believe that uniform national health plan standards include marketing requirements that can be applied to all health plans and should be required. Such consistency would benefit consumers by ensuring that safeguards, such as those for factual accuracy, would be consistent nationwide.

It is also important, however, to permit descriptions of delivery systems and rules for obtaining coverage to be sufficiently detailed before we inform consumers about the health plan they select.

GHAA has in the past commented favorably on efforts to move toward standard benefits for all FEHBP carriers, and that would be consistent with the thoughts related to regional alliances.

In the past, problems have included the potential for the established minimum benefits to be less comprehensive than commonly available HMO benefits, and GHAA has advocated differentiating between requirements for comprehensive and fee-for-service plans. This problem appears to be addressed in H.R. 3600.

The supplemental benefit plans that OPM must develop and offer may be difficult to design. They are to reflect overall benefit levels, last generally afforded under FEHBP, and benefits currently vary in significant ways among fee-for-service and comprehensive plans. Therefore, it is unclear to us how the determined required benefit levels will be developed.

We are pleased that specific provisions are included to permit enrollment in HMO's who have Medicare risk contracts. However, we have not completed our analysis of the manner in which the Government contribution is calculated and administered in order to determine its impact.

The rating and Government contribution requirements for active Federal employees would also differ substantially from the present. The cost implication for either the employee or the Government will undoubtedly be a subject of further review and discussion.

Removal of the current cap on Government contributions could make the selection of cost-effective HMO coverage options more attractive. However, our review is incomplete. And, therefore, we cannot comment on the overall impact of changing the present system of calculating the Government contribution.

In conclusion, we believe the FEHBP program is an important program for many of our plans as well as for Federal employees. We will be continuing our analysis of the treatment of the program in the context of health care reform.

It has been a very successful program, I think, and successful both from the standpoint of the employees and the health plans and the Government. And it is critical that major changes be carefully considered before being enacted. In particular, administrative issues concerning enrollment and payment must be adequately addressed.

We look forward to working with members of the committee as they consider these important issues. Thank you.

[The prepared statement of Dr. Ott follows:]

PREPARED STATEMENT OF JOHN E. OTT, M.D., CHIEF EXECUTIVE OFFICER, GEORGE WASHINGTON UNIVERSITY HEALTH PLAN, FOR GROUP HEALTH ASSOCIATION OF AMERICA

Mr. Chairman and members of the committee, I appreciate the opportunity to testify on behalf of Group Health Association of America, Inc. (GHAA) concerning FEHBP and H.R. 3600, the Health Security Act. I am John E. Ott, MD, the Executive Director and CEO of the George Washington University Health Plan, a mixed-model health plan that has been in operation for 22 years and has served federal enrollees for 17 years since 1976. GHAA represents 350 health maintenance organizations with 33 million members who account for about 75 percent of the total national HMO enrollment.

The Federal Employees Health Benefits Program (FEHBP) represents an important market for many HMOs. About three hundred HMOs encompassing close to 30 percent of the total enrollment under FEHBP are participating in the program this year. This represents real growth of HMO participation in FEHBP over the life of the program. In the early 1970's, this figure was around 4 percent; as recently as 1987, it was 18 percent.

GHAA believes that HMO participation in FEHBP has been beneficial for the federal enrollees and for the federal government. In recent years premium increases under FEHBP have been lower than those in the private sector. Although there are a variety of reasons for this achievement, an important factor has been significant HMO involvement combined with the introduction of managed care features into indemnity coverages offered under the program.

HMOs provide a comprehensive benefit package in exchange for a fixed monthly premium. Benefits include preventive services, primary care, emergency care, home health services, mental health services, drug and alcohol detoxification, hearing and vision tests, physical therapy, inhalation therapy, speech therapy and occupational therapy. In addition to these basic benefits, almost all HMOs also cover pharmacy services, allergy treatment, skilled nursing care, dental services for accidental injuries, drug and alcohol rehabilitation, hospice care, podiatry, external prosthetics and durable medical equipment benefits. Virtually all established HMOs provide unlimited hospital benefits.

Not only are HMOs known for providing a comprehensive set of benefits, their cost sharing is limited to enhance access and make out-of-pocket costs predictable. Copayments are generally low, and coinsurance and deductibles are not generally used under traditional coverages.

The emphasis on HMOs and other managed care options in the health care reform debate is both exciting and challenging to the HMO industry, and we are looking to playing an active role as Congressional consideration move forward. As the treatment of FEHBP under health care reform is considered, GHAA believes that it is a highly successful program whose accomplishments and stability should not be lightly set aside as health care reform takes place. Both the program's strengths and shortcomings can serve as an important foundation for the future.

With respect to H.R. 3600, the Administration's health care reform proposal, we applaud the President for his leadership in moving health care reform to center stage and placing universal coverage at the forefront of the American agenda. We share the President's broad goals of assuring access for all Americans to comprehensive benefits; giving our citizens piece of mind by prohibiting waiting periods and pre-existing condition exclusions; establishing the principle that all plans should be accountable for the quality of care and quality of service that they provide; and protecting the right of all consumers to choose the plan that best meets the needs of their families.

While many of these goals are well-served by FEHBP, the significant changes in the private sector framework and health benefits offerings that may take place in a reformed environment require that alteration of its structure and operation must be considered. We have not completed our analysis of the provisions of the Administration's proposal that affect FEHBP, however we can share with you issues raised in our preliminary review.

It is our understanding that, with respect to FEHBP, H.R. 3600 proposes:

Repeal of FEHBP on December 31, 1997.

For active Federal Employees: Availability of coverage through regional alliances on the same terms as other eligible individuals; and eligibility to enroll in one or more supplemental health benefit or cost sharing plans that must be developed by OPM which reflect benefits or cost sharing beyond the comprehensive benefit package that were included in the benefits last generally afforded under FEHBP.

For annuitants: At the request of an annuitant, withholding of premium; payments and forwarding of such payments by OPM to the alliance health plan in which the annuitant has enrolled; eligibility for "current" annuitants to enroll in an OPM supplemental plan (described above) and payment of a government contribution toward such a plan; and eligibility for "future" annuitants to enroll in an OPM supplemental plan without payment of a government contribution.

For individuals eligible for coverage under FEHBP but not eligible for a government contribution: Eligibility, if OPM chooses to make it available, for enrollment in an OPM supplemental plan.

Medicare eligible individuals: For "current" Medicare eligible individuals, eligibility to enroll in one or more Medicare supplemental plans developed by OPM that offer all basic benefits required in Medigap policies and reflect (in combination with Medicare benefits) the overall level of benefits last generally afforded under FEHBP

or to enroll in an HMO/CMP with a Medicare risk contract; OPM must make a government contribution toward such supplemental or HMO/CMP coverage; and for "future" Medicare eligible individuals, eligibility if OPM chooses to make it available, in an OPM supplemental Medicare plan.

As we have reviewed the Administration's proposed legislation with respect to FEHBP, we have identified several areas that merit further examination. Repeal of the program within such a short time frame does not allow the new system of alliances to become well-established before federal employees are included. While many arguments can be made for the ultimate repeal of FEHBP or continued retention of its separate identity (in a status comparable to that of a corporate alliance or in some other form), it may be desirable to consider delaying major changes beyond 1997. The program currently meets a number of major health care reform goals, such as choice of competing HMO and indemnity plans, successful control of costs relatively comprehensive benefits. Since the initial organization and operation of regional alliances will necessarily include a period in which all systems will not function precisely as planned, the stability of FEHBP for federal workers may argue for retaining the program until the alliances are in full operation and then evaluating whether to incorporate federal workers.

The most compelling reason for caution in including federal employees in regional alliances may be the significant current problem of the lack of timely and accurate enrollment information. A solution is not readily available, although a five agency demonstration project has been initiated. On an ongoing basis, HMOs and other participating plans have great difficulty confirming the employees who have elected enrollment. As you know, there is no central recordkeeping on enrollments and disenrollments, and payments frequently are not consistent with plan enrollment records.

Marketing to federal employees will also require coordination to insure that all agencies and employees receive needed information. GHAA has raised concerns about the nature of marketing materials provided to federal employees under the present program. "Standardization" of federal brochure language has made consumer differentiation between HMOs difficult in terms of their service protocols, health center locations and providers networks, and the shorter length of comprehensive plan brochures in comparison to those of fee-for-service plans has also been a concern. One aspect of this problem would be addressed by GHAA's proposal that uniform national health plan standards include marketing requirements that can be applied to all health plans. Such consistency would benefit consumers by insuring that safeguards, such as requirements for factual accuracy, would be consistent nationwide. It is also important, however, to permit descriptions of delivery systems and rules for obtaining coverage to be complete and sufficiently detailed to fully inform consumers about the health plan they select.

With respect to the desirability of affording federal employees the same comprehensive benefits available through regional alliances, GHAA has in the past commented favorably on efforts to move toward standardized benefits for all FEHBP carriers. In the past, problems have included the potential for the established minimum to be less comprehensive than commonly available HMO benefits, and GHAA has advocated differentiating between requirements for comprehensive and fee-for-service plans. This problem appears to be addressed since the comprehensive benefits proposed in the Administration's bill would be offered to federal employees under H.R. 3600 and their scope is comparable to current HMO coverages.

The supplemental benefit plans that OPM must develop and offer may be difficult to design. Since they are to reflect "overall benefit levels last generally afforded under FEHBP" and benefits currently vary in significant ways among fee-for-service and comprehensive plans, the basis for determining required benefits levels in unclear.

With respect to Medicare eligible federal employees, we are pleased that specific provisions are included to permit enrollment in HMOs that contract with Medicare on a risk-basis. However, we have not completed our analysis of the manner in which the government contribution is calculated and administered in order to determine its impact.

For active federal employees, the rating and government contribution requirements would also differ substantially from the present. The cost implications for federal employees and the federal government will undoubtedly be a subject of further review and discussion. Removal of the current cap on the government contribution (75 percent of a plan's premium) could make the selection of cost effective HMO coverage options more attractive. However, our review is incomplete and we cannot comment on the overall impact of changing the present system of calculating the government contribution.

In conclusion, FEHBP is an important program for many GHAA member plans, and we will be continuing our analysis of the treatment of the program in the context of health care reform. It has been a very successful program for federal employees, for the health plans that serve them and for the federal government, and it is critical that major changes in FEHBP be carefully considered. In particular, administrative issues concerning enrollment and payment must be adequately addressed. GHAA looks forward to working with members of the committee as consideration of health care reform proceeds.

Mr. CLAY. Thank you.

Mr. Cain and Mr. Miles, have your organizations done any analysis comparing the actuarial value of the standard nonpreferred providers organization benefits with H.R. 3600's high cost-sharing plan?

Mr. CAIN. We have completed some.

Mr. CLAY. How does it compare?

Mr. CAIN. I will give you a brief overview, and Alan Spielman here has some more specifics that he can provide. Generally speaking, it is hard to compare what is being proposed in the high-cost plan with any FEHBP current plan's product. But if you assume that, for example, our most popular product—our standard option plan—is essentially the same as what the President's plan would offer, then you find that the prices around the country for that same product would range very widely.

We have examined a few areas, and I'll ask Alan to provide the specifics.

Mr. SPIELMAN. Mr. Chairman, I'd be happy to provide any of the material I'm about to give you for the record subsequent to the hearing.

We have looked at our total premium for standard option relative to CBO's analysis of the Clinton proposal and find that the total premiums are comparable. The single premium of standard option is a little bit higher. The family premium is significantly lower.

Again, Mr. Cain mentions that he's looking at it on a national basis. And, indeed, when one distributes enrollees under the alliances and has different risk pools, the actual premium may differ substantially.

In addition, on a more anecdotal basis, we have looked at some common procedures and compared the benefit levels of our standard option with that under the high cost-sharing plan.

For example, under a normal delivery, if one combines the hospital and physician charges of about $7,500, an enrollee in 1994 in our standard option plan going to preferred providers would pay about $315 out of their pockets. Under the high cost-sharing plan, they would pay $1,500.

Similarly, and just one more example, on a heart bypass, the same comparison would yield an out-of-pocket cost of $665 under standard option today, but a $1,500 out-of-pocket cost under the high cost-sharing plan.

Indeed, a lot of caveats are associated with any of this, but that gives you a flavor for the types of figures we're talking about.

Mr. CLAY. Are you assuming that the benefits of the President's plan are identical or very similar to the ones that you presently have?

Mr. CAIN. Yes, close. I should add one other point. What we're talking about here are what we call the pure premium assumptions, but now does not indicate what prices would be set around the country.

One of the problems with the President's proposal is it is going to create these very complicated agencies having many challenges. And when the actuaries view how to set a price for a plan in that environment, that environment has introduced many new uncertainties and, not surprisingly, actuaries resigned to uncertainty by raising prices.

One of the reasons that prices in the Federal employees' program have remained so solid in the last several years is that there is a very high degree of confidence as to how it works. That wouldn't pertain in this future that the President is proposing.

Mr. CLAY. Mr. Miles, has your analysis pretty much coincided with what Mr. Cain has said?

Mr. MILES. Our actuaries are currently in the process of completing their studies, and we'll supply those to the committee when they're done. But I would say our anecdotal evidence is very much like Harry Cain testified.

We're very concerned for our membership in certain high-cost areas. We see that the premium could vary widely across the country and, in particular, the DC district.

Mr. CLAY. In your written statement, Mr. Miles, you said that the Clinton plan would put you out of business. Can you not see any circumstances under which you would be able to join a regional alliance?

Mr. MILES. It's going to be very, very difficult for us to compete under the Clinton health care plan for a variety of reasons, which Kel had previously talked about.

We would have to become certified by 50 different States. We would have to set up offices probably in 250 different regional alliances, and comply with all of the different rules that all of those alliances come up with. We don't have the marketing system in place now to compete regionally.

But probably the biggest hurdle for us is that we're a 501(c)(9) organization, which is an employee organization plan under the IRS code. And it provides that we can provide benefits to our membership, but that membership has to have commonality of employment. And commonality of employment for us is the Federal Government.

The Clinton health care plan would require us as an accountable health plan to open up our membership to all comers, and that commonality of employment wouldn't exist. So we would have to try to get the law changed to be able to compete.

Mr. CLAY. Mr. Ritter, what did your analysis of the low cost-sharing plan's benefits conclude?

Mr. RITTER. We are still in the process of looking at what the costs would be. One of the benefits of an HMO is that we use community rating. In trying to identify the costs represented in the Clinton health care plan and comparing it with the community rating system that we presently use is causing a few problems.

We should be able to have that information available for the committee, I'd say, in about a week-and-a-half or two weeks, I would be glad to make it available to you.

Mr. CLAY. We would appreciate getting it.

Mrs. Morella.

Mrs. MORELLA. I guess you're all in concert with regard to the FEHBP program working fine and this is going to cause a lot of problems for your clients as well as the firms that you represent and the entities that you represent.

I'm curious about how State laws apply to you. I say that because Maryland, as an example, passed a health care bill that deals with standardized forms and setting up of commissions, a hospital commission and insurance commission. How do they generally apply to you in the FEHBP program?

Mr. RITTER. I know from our standpoint, if there are State-mandated benefits available—and I can think of three other States we serve where mental health and substance abuse benefits are mandated. Where those mandates exceed the current basic benefits proposed by FEHBP, those State-mandated benefits are the ones offered to Federal employees, who live in that State.

If FEHBP establishes a minimum level of benefits, it's conceivable a State could mandate benefits that are less than FEHEP requirements. In those cases the FEHBP benefit would be used. In most situations, we have not had a problem matching or offering the State-mandated benefits because they have not varied that widely.

Mr. CAIN. I should add for the other plans who operate generally under a fee-for-service basis, the FEHB Act includes a Federal preemption, which permits us to offer the same plan all over the country.

Mrs. MORELLA. Did you want to comment on that, Mr. Miles?

Mr. MILES. When State law conflicts with the Federal program, the Federal preemption comes into play. We've had some difficulties, particularly in the State of Maryland, because of our lack of ability to negotiate individually with hospitals for preferred provider networks.

Mrs. MORELLA. It sounds as though you have the Federal preemption, but if you have coverages that the States require, you try to rise to that so that you do offer that. And in most instances, you do.

But let's say this idea of a computerized form, a single form, computerized card for billing, do you find that you try to abide by them or are you required to? I guess you're not required to, then. Is that what you're saying?

Mr. MILES. No. I would like to add—and I think that GEHA is no different than Blue Cross or some others—that we don't require a standardized claim form. We'll accept any claim form that has the information on it that we need to process the claim.

So some of the publicity that we've heard about insurance companies and all their forms I, quite frankly, don't understand.

Mrs. MORELLA. Did you want to comment?

Dr. OTT. If I could just add to that, I would think that there would be very little objection to the adoption of a uniform billing form. I can't see where that poses a problem at all.

Mrs. MORELLA. See what I'm getting at is that there are some of us who feel that we should proceed with some incremental steps where everybody agrees they need to be done—and that would include malpractice tort reform and the standardized form, no preexisting conditions, which I know you do abide by already. I just wondered how that would apply to the current FEHBP program. Is there any——

Mr. CAIN. Well, that's essentially how it presently works.

Mrs. MORELLA. I know those are things you do already.

Mr. CAIN. Yes.

Mrs. MORELLA. But I mean anything beyond that.

Mr. CAIN. I don't think there's any requirement in the President's bill that would push us or the Federal employees' program further than it currently operates and has for a long time.

Mrs. MORELLA. Well, I don't know that I'll pursue that further. I just think you need something that could pass, that everybody is in agreement on, and that might even enhance the FEHBP program.

I do remember, though, from the time I came to Congress that there were times when there were some real highs with regard to premiums and the complaints that we heard from our participants. And now we have in the last few years reached a point where the increase has been smaller and then this year 3 percent and in some instances a reduction.

This is not to say that there is a need for continued monitoring of the program. We happen to be in a position now where it looks good. But what's going to happen a few years from now?

Do you have any suggestions? If, in fact, you feel that this program is the one we should stick with and should, in fact, be a model for the Nation, would you suggest that there is some additional way that we could monitor, that we could make sure that we're not going to see tremendous highs? I realize you count on the market for that, too. Can anybody comment on that?

Dr. OTT. I think that in general, to the extent that we can standardize benefits and standardize administrative procedures, not only from the standpoint of the FEHBP, but also from the broader standpoint of health insurance, the easier it is to analyze where our significant variance is and to try and determine what might be the cause of those variances.

We're a relatively small plan which operates in three jurisdictions, all of which have differing requirements, which is obviously an administrative burden and, therefore, an administrative cost. If we have 50 different or 250 different health care alliances, each of whom has the ability to determine different benefit packages, different administrative systems, different rules and regulations, it will be an administrative morass, which can certainly drive up costs, but also obfuscates how you evaluate the successes and failures that we as an industry are having. And I think it is very important that we try to do as much standardization as possible.

Mr. RITTER. One of the things I would just like to add is that in some of our marketplaces there are approximately 20 to 22 other HMO's offered to employees. I don't want to mislead anybody but

you should understand that we do look at our rates and also consider the other competitors in the marketplace. We consider the potential for what they will be offering and what their rates will be.

So I think the marketplace itself in the present environment dictates to a certain degree what our rating structures are going to be. And I think competition is very useful, particularly from the employees' standpoint because they benefit by being offered a good-quality package of benefits, but also with concern given to what is the competition going to offer to them and what rates are going to be charged for those benefits.

Mrs. MORELLA. I notice that, Mr. Cain, you mentioned in your testimony many of the innovations that Blue Cross/Blue Shield has had, and I know you do have some competition.

I'm reminded of Mr. Ackerman's bill, which would enhance the FEHBP program. And now it appears as though we think that that program is a pretty good one in comparison to the others.

Mr. Ritter, you also said that you thought we should let the current system work for a period of time—I mean under a new system, if we go into a new system, as the administration has suggested, H.R. 3600, that we should let it work for 9 months or something. Would you like to comment on why you think that should be the case? Is it simply a stay of execution may mean it won't work and, therefore, we won't have to worry about it or——

Mr. RITTER. One of the comments I made earlier was that in California, a voluntary program had been put into place for small businesses in July of last year. It is a system where small businessmen can participate, but they're required to pay 50 percent of the premium for their employees.

As of right now, I think about 25 percent of the employers are participating in that on a voluntary basis. I think if programs of this nature are made available to smaller employees to participate in, you're going to find a lot of voluntary participation without it being either regulated or mandated and additional costs being thrown into it because of the administration associated with that type of mandate.

Mrs. MORELLA. I want to thank you all for testifying. I think you wanted to add a final comment, Mr. Cain, and I'll turn back to the chairman.

Mr. CAIN. Just two points. I certainly support your observation that while this program is now operating very well, we can't assume it will always be so. And, hence, it does require OPM to watch it closely.

One of our concerns I'd like to add is that we have some proposals for how to improve our product in the Federal employees' program. And when we have talked about this with the Office of Personnel Management, their attitude has been that since health care reform is on the table and it might take a while to achieve it, there really isn't a very good case for improving what exists here. Why don't we just sit tight?

We hope reform happens soon, but it might take several years. And we're very concerned about having to sit tight over that period, whatever it is.

Mr. CLAY. Thank you.

Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

I had started to indicate that at least the sensitive political question is raised if FEHBP continues. Are you in effect arguing that Federal employees should become, in effect, a corporate alliance?

Mr. RITTER. Assuming that this is a continuation of the first question you asked earlier, one of the things that AMCRA has proposed is that alliances, if there are going to be such things, be limited to just employer groups of less than 100, which would immediately exclude Federal employees. They also should be voluntary, and they also should be nonregulatory.

If those types of alliances are allowed to pass, then, again, Federal employees would automatically not have to participate. I guess we also question what is to be gained if Federal employees were mandated into a situation like that.

Ms. NORTON. With the understanding that there is reluctance, obviously, to take what has become something of a model and dismantle it in the name of reform, I think the burden is on us to come up with rationales that do not treat Federal workers in a special way or to come up with alternatives, such as these one of you have offered, although I'm not sure that I see how it is an alternative.

The notion that FEHBP should be open to everybody seems to me to raise a whole series of questions that nobody's thought through. I don't know if we would have a competing national alliance here, competing with whatever other system is set up—and I'd like you to elaborate on that—or on any other suggestions you may have to respond to the notion that FEHBP should be kept as it is.

Mr. CAIN. A couple of responses come to mind. First, regarding what would be offered if the Clinton proposal as it now exists did pass the Congress, what should happen to the Federal employees' program, we would argue that the Federal Government ought to be viewed as any other large employer. Most very large employers won't want to have their employees spread among all of these regional agencies.

To your second issue, of opening up FEHBP to others, it is a technically feasible option. This program is available everywhere in the country and offers choices everywhere, it would deserve a lot of review. It offers a consumer choice opportunity that other large employers might want to take part in. It might be a fallback option for individuals around the country who otherwise fall through the cracks. It is an idea worth exploring, it seems to me.

Mr. MILES. I would agree with everything that Mr. Cain said. In addition, I don't think it would be fair to treat Federal employees any worse than any other large employer.

Ms. NORTON. You oppose mandatory health alliances. We recognize that the administration has gone to such devices as mandatory health alliances and employer mandates because it's trying to achieve universal coverage.

I wonder how you imagined that without mandating some of these features, universal coverage, not access, but coverage, would be possible.

Mr. CAIN. We have supported strongly all the same aims as the Clinton proposal, including universal coverage. These mandatory

health alliances aren't at all essential for achieving any or all of the objectives.

Apparently one of the major aims in the White House of putting such emphasis on these regional entities is that it would allow widespread subsidies, particularly for Medicaid, without making it obvious to the world. We do agree that the Medicaid Program is very important. It should be improved. But you don't have to hide the subsidies to achieve it.

So we think that all of the President's aims can be achieved without that one onerous device.

Mr. RITTER. I tend to agree with Harry on that one. I think that universal coverage can be provided for all employees, all members of society, whether they're working or not, without having to go through an alliance. I think that some of the programs we have now, Medicaid or something similar to that can be put into place to cover those employees.

Ms. NORTON. One last question. I have a special interest in mental health benefits. Of course, the word "mental" health covers not only traditional mental diseases, but substance abuse.

Have you found that managed care has helped to manage or contain in an effective way mental health costs without discriminating against people who may need these services? I'm talking about discriminating on the basis of a limitation on these services that is not attached to other services.

Dr. OTT. I think the fundamental question here is that an insurance company or a health plan can provide whatever coverage the society determines it wants and is willing to pay for.

I think one of the problems that we're struggling with now is that many of the state mandates are well-meaning, but poorly executed; for example, emphasizing inpatient hospital treatment, when that's not the way to manage many mental health problems.

I think as long as there is a uniform benefit package and as long as that benefit package is applied across all carriers, including self-insured groups, we can provide whatever people believe is necessary.

I think the problem derives when you have individual mandates requiring things which are medically not necessarily appropriate and which were applied differently in different jurisdictions and which allow self-insured groups to opt out of that particular type of coverage altogether or perhaps to put in a much more restrictive package. That's what creates the problems.

Ms. NORTON. Are you concerned with, for example, that we might get treatment on demand, which has been a slogan until now? But presumably if there's universal health care would be quite possible for addicts or people who are alcoholics to for the first time walk into one of your clients and say "I'm ready for my treatment on demand," do you believe that the proposal, the President's proposal, envisions the costs that might be involved?

Dr. OTT. My personal opinion is that the President's program underestimates a lot of costs. And this is one area where it's very difficult to predict what changes in demand there will be.

As a physician, I consider these to be medical problems in the same sense that I consider cancer or some other problem to be a

medical problem. And these things are certainly worthy of treatment, and we should make a reasonable attempt to treat them.

I think we all can see that there are some patients whom we cannot help, and those patients need to be identified. But I think the people deserve an opportunity to receive the appropriate treatment.

Ms. NORTON. Yes, sir?

Mr. SPIELMAN. In the Blue Cross/Blue Shield plan, our mental health and substance abuse benefits are about the richest in the Federal program. Indeed, this is an area where I think as we proceed over the next few years and look at benefit design and how we might want to restructure benefits, particularly in light of new managed care techniques that are coming on line, it is appropriate, I think. With or without the Clinton health plan, there needs to be a lot greater attention to this area to see how we can improve the management of that care while at the same time enhancing benefits.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. CLAY. Thank you.

Mr. Ackerman.

Mr. ACKERMAN. Thank you very much, Mr. Chairman. I did have an opening statement that, without objection, I'd like placed in the record at the appropriate place.

Mr. CLAY. Without objection, so ordered.

[The prepared statement of Hon. Gary L. Ackerman follows:]

PREPARED STATEMENT OF HON. GARY L. ACKERMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I would like to welcome our distinguished panel today and thank them for their testimony. Their contributions are very valuable and timely in this stage of health care reform.

There are many factors that we need to consider before voting on a health care package, and we are here today to contemplate, together, what the options, implications, and consequences may be.

As a member of this committee, I am concerned that we are able to maintain the same high level of benefits that Federal employees currently receive and have earned throughout their years of service.

I am very reluctant to support a health plan that will provide its beneficiaries with less coverage than they are receiving under their current plans.

In fact, my original answer to the question of universal health care was to provide the rest of the country with the same effective and comprehensive benefit packages that Federal employees currently receive.

My colleagues and I are faced with many options. Many have sugested that we embrace the single-payer option as a method plan to achieve the administration's goal of universal coverage.

Like President Clinton, I believe that the bottom line on health care reform must be universal coverage. The question before us, of course, is what road do we take to reach this laudable goal?

For this very reason, we have invited these witneses here today, so that we may continue to discuss the potential results that the various health care altrnatives may generate.

Mr. ACKERMAN. First, if I can just follow up on the question that was very appropriately asked by my colleague, the distinguished Chair of the Subcommittee on Compensation and Employee Benefits, the question basically addressed the issue of the very special category in which mental health benefits finds itself. And that is that it seems to be one of the very few general areas upon which there is placed a cap.

Dr. Ott, you mentioned as a physician you would like to see all people treated appropriately if somebody came down and that mental illnesses are the same as cancer. But if somebody had cancer and somebody prescribes that they have to go through 37 treatments of chemo or radiation or something, there's not a cap that says you can only go 7 times.

With most of the mental health benefits, we have caps of "x" amount of dollars. We don't say that if you have diabetes, that you can't spend more than $30,000 in your lifetime. We do say that if you have an illness that affects your brain. And I think that was the question that——

Dr. OTT. I think that, obviously, the area of mental disorders is a very complex one. It's much more difficult to understand. There's not the same degree of uniformity of agreement as to the treatment approaches or how to evaluate the effectiveness of the treatment approaches that we utilize.

There are things which have historically been societal obligations; for example, the institutionalization of a patient with a mental disorder. A nearby State has recently passed a law which will require 365 days of hospitalization for such a person.

This has traditionally been a societal expense. There's no reason why insurance companies can't do that if that's what you, society, believes should be done, but we have to understand there's a cost attached to that.

Mr. ACKERMAN. Yes, but for some reason yet unknown to me, certainly unfathomable to me, there are decisions made that if you put somebody in the hospital, you get reimbursed better than if you get treated as an outpatient.

Dr. OTT. That's part of the irrational treatment.

Mr. ACKERMAN. It doesn't make any sense. You know, some people have their physicians put them in hospitals, rather than treating them in a fashion that's a heck of a lot cheaper. In the hospital, they only see the same guy for 45 minutes anyway.

Dr. OTT. And it would make much better sense to take a different approach and not be that proscriptive as to how a patient should be treated. If we want to broaden the benefit, we can broaden the benefit without necessarily describing that it must be delivered in a hospital or some other setting which might be appropriate at one point in time but not be appropriate at a subsequent time because we have new techniques, new drugs, new approaches to treatment that might be more effective at a much lower cost. I think these decisions are best left in the hands of health professionals.

If we wanted to say unlimited or a mental health visit per week, every week of the year, that's a very expensive benefit as long as it's used when it's medically appropriate, I don't personally have a problem with that as long as it applies across all carriers and across self-insured carriers as well and that people understand there is a cost attached to that which will drive up the premium.

Mr. ACKERMAN. I think you're absolutely right, and it's an issue that has to be visited, regardless of which health care system we speak of.

We are on the horns of a dilemma here. And in discussing this, you have collectively, the FEHBP program, basically been lauded

as the panacea, at least by a great many people who have worked with this program. I just want to make sure you don't get a completely free ride out of this deal. I guess it's a matter of the devil that you know versus the devil that you don't know.

We have had some great concerns about FEHBP over the years. Certainly a lot of people are more comfortable with it than the unknown, but, nonetheless, there are issues that yet must be addressed within FEHB and which are being held up here today as part of the answer by comparison to a system yet untested, as has been pointed out, which aren't necessarily so.

Even within FEHBP, there are regional differences in cost today in different parts of the country. There is sometimes no correlation between the benefits packages and the premiums. You can pay a much higher premium with some policies and get much less of a benefit package.

So that when you want to buy the most expensive car, you think you are getting the best car, and you're not necessarily getting that. A lot of Federal employees have found that out over the years.

So stating that that would be true under a different plan without acknowledging it as existing within the current structure would not be fair to the system to allow that to stand unchallenged.

Does anybody wants to comment on that?

Mr. CAIN. Mr. Ackerman, I would make two comments. First, in terms of comparing what we have to a lot of unknowns, I would point out that comparing the FEHBP to many other health care programs in the country which exist and we do understand how they work, FEHBP still scores very well. It's just a fine program as it is presently working.

Second, on your point about in some instances there is a very large gap between what are the offered benefits and the prices of the premiums, we can explain how what we've got now exists, but it underscores the point that there are still some improvements which ought to be made in this current FEHBP.

We are anxious to proceed to make such improvements, but we aren't getting a lot of encouragement from OPM due to the current debate, and the President's proposal, on general health care reform.

Mr. ACKERMAN. We do have legislation, as you know because we've worked on it together, that would reform the FEHBP. And I guess that reform package is looking a heck of a lot better, even from your side, when faced with the possible option of reforming the whole system out of business and placing in its place some system yet untried.

Mr. CAIN. We would still offer some changes in that reform proposal.

Mr. ACKERMAN. I'm sure. Let me ask this question, which I think is crucial to the dilemma in which we find ourselves. I think it's the consensus, as I've heard from the panel, that you would like to see, as many of us would, the ability of one of the Nation's largest employers, the Federal Government, being established as its own health care alliance, if you will, and to provide that benefit as a major employer to its employees. And many of you have so stated this morning.

The problem that we face is that in setting up a system, as the administration has proposed, which allows major corporations to opt out and basically self-insure or come up with their own program, if they would like, we have to face the political climate out there. And the weather lately has not been good. We have to face the political climate of saying we're going to set the system up for the whole country, but we're going to be the first employer to opt out.

Now, I don't know how you sell that to the American people with a straight face. I think the easier deal would be that we would like to set this system up for the whole country and ask the American people and maybe the employers to opt in. I think it's a much easier sell to tell people they can have the same insurance plan as their Congressman, which we get those letters all the time, you know.

I read them. Some of them are nasty. And some people don't realize that, nonetheless, some of them have better plans than we do. Our plan is not as generous as in the private sector. And I think that all of the studies have shown that Federal employees under FEHB have a plan that's basically $1,100 a year less generous in its benefits compared to appropriate private sector plans.

If we would set this up—and the reason so many people have a problem with even other companies of over 5,000 or 1,000 or 100 or 500 opting out, that that basically is cherry picking. If the purpose of insurance is to spread the risk over the greatest number of people and you remove from the system your presumably because they're younger, presumably because they're working population, the residual population that's left is older and sicker. And it's going to be more costly to provide the kind of coverage that the opt-outs will get.

If, indeed, the Federal employer opted out of the system, what in your opinion would be the impact on the health alliances, the other health alliances, across the country if the President's plan were the plan?

Dr. OTT. It would seem to me that in order for this to be sold as a public policy, the plan has to be perceived to be equitable. That can easily be done by providing the same conditions in terms of benefit coverage, same regulations, the same contribution to charity care, or in the case of the Government will probably be more anyway, as other major employers would pay.

I think if you look at it from the administrative burden point of view, I believe we have something like 300,000 Federal employees and their families in the Washington area who are currently under FEHB. If they were to be moved into health care alliances, that would be 300,000 more patients whose records, payments, and so on, would have to be recorded in a new system, which is just getting off the ground, which is going to have its bugs to be worked out in any event, which will only complicate matters.

While I appreciate the fact that you from time to time hear from your constituents and I'm sure from time to time you hear about benefit plans and individual plan experiences, the actual number of complaints is relatively small. And I can only believe that if you dump 300,000 people into these newly emerging alliances that are

already struggling administratively, that you will hear from a lot more for things over which you really have very little control.

Mr. ACKERMAN. You really believe that alliances would have objection to adding an additional client base of Federal employees?

Dr. OTT. I don't think they will object, but I think if you look at the problems that the Federal Government has allocating funds to the plans it now contracts with and you add in some variable number of alliances on top of that, it can only make the system worse.

Mr. ACKERMAN. Well, I'm neither a physician nor an actuary, but one would think that if you took 300,000 Federal employees in the Washington, DC, area and compared them to the general population of nonfederal employees in the Washington, DC, eligible area and offered that to anybody's particular company as to which they would rather insure, that it might surprise you that they would want to insure the Federal employees.

I think you get a better return on your dollar if you do. And I think that that would probably raise the whole base of it if you did that. And I think that that's the point.

Dr. OTT. Right. I don't believe that most insurance companies would agree that the Federal employee group is necessarily a low-risk group.

Mr. CAIN. Here in the Washington area, it may be.

A couple of other points. We have examined this issue of what impact would Federal employees have all over the country on these regional health alliances. In most areas, the Federal population would have an imperceptible effect.

Certainly here in the Washington area, it would have a huge effect, but in the vast majority of the country, it wouldn't affect the alliances one way or the other.

And I have also observed that there are other large programs that are being exempted or excluded from this program, CHAMPUS, the VA, Medicare. So the Federal employees would not be the only exempted entity.

Mr. ACKERMAN [presiding]. If large States opted to go to a single-payer system, which is possible under the President's proposal, how do you think that would affect you?

Mr. CAIN. Let me be sure I understand. You mean how would it affect Federal employees in such areas?

Mr. ACKERMAN. Yes.

Mr. CAIN. Well, that would depend very much on what the program was that the State was trying to set up. It would certainly make it much harder for you or for OPM to have any way to remain accountable for Federal employees in that area, but that would vary widely depending on whatever the specific proposal is.

Dr. OTT. I think if you look at the Washington area, it's a very instructive situation because we're faced with a peculiar situation in the sense that we have three jurisdictions that really interrelate to as large degree.

But if OPM were classified as a D.C. group and came under the D.C. alliance, you would be faced with the fact that you would have 200,000 underinsured or uninsured people, which would have to be figured into the premium, which is going to dramatically increase your premium.

And to the extent that you chose to be a Maryland group or a Virginia group or some other group, that would certainly not be perceived as being equitable perhaps since we have a large number of employees who are, in fact, D.C. residents or workers. So I think that would have a significant impact on the program.

Mr. ACKERMAN. If we were to use the FEHB as not just a national model, but as a national plan, how would you cover the presently uninsured?

Mr. RITTER. Basically you're saying those people who currently have no coverage would be allowed to participate in FEHB as we currently know it?

Mr. ACKERMAN. I'm asking how you would treat them. Would you allow them to participate in FEHB?

Mr. RITTER. From an association standpoint, we would have no problem in that situation. One of the problems that we foresee is identifying who's in and identifying who's out.

I know some of the concerns that we have now in dealing with OPM is to identify existing Federal employees. I see this situation being compounded by people who would be sending their checks to OPM for premium payments and OPM, in turn, sending those checks to the plans to pay for the care.

Mr. CAIN. Mr. Chairman, may I be sure I understand what you're asking? Who would be paying the premium for such uninsured people?

Mr. ACKERMAN. That is exactly the point. That is the question. If we were to try to put together a package, as some have suggested, that we use the Federal Employees Health Benefits Program, which is the largest such plan in the world, and impose that as the national structure and treat everybody in the country as eligible for FEHB and allow all employers access to the same plan, paying the premium on the percentage breakdown that they do now or better or some Federal standard as a minimum, how would we set about covering the premiums for those who are not insured?

Mr. CAIN. Presumably the same way that the current President's proposal would. It includes a number of different forms of public and private subsidy for all who cannot now afford health insurance of any kind. So whatever the sources of that subsidy, if they were available to funnel into the Federal employees' program, at least in theory it would work.

Mr. ACKERMAN. What's your feeling about undocumented aliens? I mean, it's clear from the language that the President has used in talking about the proposal that he has placed before us that every American—and that's the operative word—will have that card. Those who are undocumented aliens will not.

Is that wise to do as a matter of public policy?

Mr. CAIN. Wise——

Mr. ACKERMAN. I know politically it's probably a good deal because a lot of people think we'll be giving something away for free to people who got into the country illegally.

But from an insurance point of view, is it wise?

Mr. CAIN. Well, I think you put your finger on the issue. There is, as they say, no free lunch. If you include all such people, who is going to pay for their care? Are we going to be very much up front about it with some explicit subsidy or aren't we?

Mr. MILES. That would be a very, very difficult group to insure because of the identification problem and collecting the subsidy. I certainly think I would hate to be a hospital administrator and be turning these people out because they didn't have coverage. I would think some kind of subsidy to hospitals would be a better way to handle that.

Mr. ACKERMAN. Well, we do that right now, do we not?

Mr. MILES. Yes, we do.

Mr. ACKERMAN. But what happens is there's some kind of a discrimination on a regional basis, where you have a disproportionate number of people who are undocumented or homeless, for that matter, who, by and large, find themselves in some of our larger urban areas impacting upon the health care system, which becomes inadequately reimbursed by the Federal Government.

You have places in New York and Florida and Texas and California where hundreds of thousands of people, sometimes approaching 1 million in some metropolitan areas, are using the hospitals as there primary health care provider, having access to the health care system, not necessarily being heartlessly turned away.

And if we would set up regional plans, would that not concentrate the entire burden of that population on the individual areas?

Mr. MILES. Absolutely.

Mr. ACKERMAN. Places such as Washington, DC and the greater Washington area——

Mr. MILES. San Diego, CA. Exactly.

Mr. ACKERMAN [continuing]. Are where you have large amounts of people who are way below the poverty level.

Mr. MILES. Absolutely.

Mr. ACKERMAN. If there were a proposal to set up a pool such as in the automobile industry, where you have a high-risk pool, doing it slightly differently under a health care kind of plan and saying that basically undocumented aliens are a national problem because it's a Federal Government's responsibility to patrol our borders, No. 1, and not the local area's, which wind up being impacted the same as the homeless, and putting all of those people in some kind of a pool—I don't know if you'd call it a high-risk pool or whatever title you'd want to give it, but put them within a pool and then take a proportion of that and spread that premium across the country so that everybody would pay a share of that, people would know what the cost was to America. What would your reaction be to such a proposal?

Mr. MILES. It sounds logical to me.

Dr. OTT. I think from a delivery system point of view, it probably makes good sense because there might be a better chance of getting people into more appropriate forms of care so they're not seeking care necessarily in the emergency room or waiting until the last-ditch effort at the hospital. From an administrative point of view, it obviously is a much more complex problem that would need some careful thought.

I think the idea is not a bad one. There are many countries in Western Europe where a foreign resident who happens to become ill in those countries will be taken care of at no charge, even though they may have the ability to pay.

Mr. RITTER. I think it's doable. But, again, as Dr. Ott says, the administration of how you do it would probably be the key. And I think that would really be complex.

Mr. ACKERMAN. Complex but less costly?

Mr. RITTER. I can't answer specifically on that one. I think identification becomes the key, identifying who—is covered by your plan and who is not.

Mr. ACKERMAN. I've made a decision, as most people I know have made decisions for their families, that we want to provide our dependents with insurance because we would rather pay their insurance premiums than their health care bill.

And if we say there are millions of people in this country who are either undocumented or homeless and can't pay, they're my dependents as well. They're our collective dependents.

And having made the decision once based on sound reasoning, I think that I would rather pay the premium than the actual cost of the bill, then why wouldn't I want to do that for my other dependents?

It would seem to me that I would want to jump at that chance as a society because the medical costs of those other dependents that we share collectively are probably much higher than our individual dependents that we claim on our taxes.

Mr. CAIN. Mr. Chairman, I don't think you're talking about insurance, however, for this group. If it were insurance, you would have to understand very clearly, person by person, who was insured, and make some kind of a premium contribution for each one into some pool of the kind you're describing.

Here's where the problem is. It is identifying who is in this pool and figuring out how to make some sort of insurance payment for each one. Administratively that is very tough.

Dr. OTT. I think philosophically your point is a very good one. One alternative approach might be to provide more subsidies to some of the clinics which are already in existence serving these populations.

I certainly have done no national study, but in the Washington area, we have a number of clinics specifically aimed at these populations which we as a plan help to support as well as many other private individuals. And these groups already have connections in the community and, therefore, have more ready access to many of the people.

Perhaps another approach might be to provide more subsidies to these groups so that they can be more effective in carrying out their desires.

Mr. ACKERMAN. Mrs. Morella.

Mrs. MORELLA. I think it's a very interesting idea because we do in Maryland have the uninsured motors pool.

I just wanted to ask you: If we continue to keep the FEHBP program as it is, what would the impact be of the health care board that would be established, that seven-member board, on the FEHBP program? Would they be doing some global financing reflecting costs have gone up? How would that interrelate?

Mr. CAIN. I don't know.

Mr. ACKERMAN. Well, I think this is the point at which we should wrap this up. Let me ask especially if this distinguished panel

would continue to think about some of the answers to the questions we've raised.

This hearing is going to be concluded, but the debate on this issue is going to rage on, you can be sure, and be certain that we are receptive to your ideas as to how to make things better and less scary, both for Federal employees and for all Americans. Let me thank you for your expert testimony here today. Thank you very much for attending. This hearing stands adjourned.

[Whereupon, at 11:38 a.m., the committee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF HON. BARBARA-ROSE COLLINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I am very pleased to join you and the other distinguished members of the Post Office and Civil Service committee in our continued discussion of H.R. 3600, the Health Security Act of 1993, and its affect on the Federal Employees Health Benefit Program [FEHBP].

I would like also to take this opportunity to thank our panel of witnesses for taking the time to share with us their organization's views on the administration's health care reform plan. I am extremely interested in hearing from organizations that have proven themselves successful in implementing managed care plans and fee for service plans for millions of Federal employees.

Like millions of Americans, I am concerned about the spiraling cost of health care. As I have stated for the record, in previous hearings on this subject, I am equally concerned about the proposed health care plan and its affect on the coverage it will provide Federal and postal employees. In particular, I am concerned that the benefits and services from the enactment of the President's plan will not be as good as the current benefits received under FEHBP.

I believe this committee should give serious consideration to maintaining a separate system for Federal employers that provides them with at least the level of benefits currently received under FEHBP.

Clearly, there is room for improvement in the current health benefits provided to Federal employees. The proposed plan, at present, may leave some individuals better off, but clearly not all.

We, as elected Members of Congress, are obligated to work with the administration to shape and develop a health care system that works for all Americans. This, unfortunately, can only be accomplished by asking the tough questions.

I trust therefore, that during the course of today's hearing, this committee will further examine those aspects of the proposed plan which need strengthening so that a national health care policy can be developed which everyone can benefit from and enjoy.

PREPARED STATEMENT OF RICHARD E. RUDDICK, GROUP VICE PRESIDENT, FEDERAL EMPLOYEES HEALTH BENEFITS PLANS DIVISION, CNA INSURANCE COMPANIES

Chairman Clay and distinguished Members of this Committee, I thank you on behalf of the CNA Insurance Companies ("CNA") for this opportunity to submit testimony on the provisions of the Health Security Act, H.R. 3600, that affect Federal and postal employees and annuitants. CNA possesses wideranging experience in the current health care market. We currently offer medical malpractice, workers compensation, long term care, and of course group health insurance products. Since 1976, CNA has insured that the Mail Handlers Benefit Plan ("MHBP") provides health care security that's always there for its postal and Federal enrollees and their families which now number over 1,500,000.

CNA fully supports the President's goal of offering all Americans the same health care protection afforded to MHBP members. While we do not support passage of the Health Security Act as introduced on November 23, 1993, we do agree with the following key reform principles embodied therein: Federal law should require all employers to provide and pay for a substantial portion of the cost of health insurance for their full time workers and a pro rata share for part time workers, provided, however, that subsidies and a phase-in period are granted to alleviate the burden

on vulnerable businesses and employers; Federal law should require all health insurance coverage to include guaranteed issue and guaranteed renewability (no denial of coverage because of health or claims experience) provisions and should prohibit pre-existing condition exclusions and waiting periods. However, we part company with the Administration on certain aspects of the bill which, in our view, are inconsistent with achieving the goal of universal coverage at a reasonable cost.

In particular, we oppose the Health Security Act's intended abolition of the Federal Employees Health Benefit ("FEHB") Program. We fully agree with the National Postal Mail Handlers Union, AFL–CIO, the MHBP's employee organization sponsor, that preservation of the FEHB Program is consistent with the goals of health care reform. Moreover, we believe that the FEHB Program—which is widely hailed as the model for reform—can and should be utilized to set the pace for health care reform over the next decade.

The FEHB Program, of course, is the Nation's largest employer-sponsored health insurance plan. It currently provides quality health care benefits at an affordable cost to approximately 10,000,000 Federal and postal employees and annuitants and their dependents. Those employees and annuitants annually are allowed to select coverage from various experience rated fee-for-service plans, such as the MHBP and the Blue Cross Blue Shield Government-wide Service Benefit Plan, and health maintenance organizations ("HMOs") under contract with the U.S. Office of Personnel Management ("OPM"). The principal distinction between these two types of plans is the degree to which the patient may choose a provider of care. Fee-for-service plans allow broad freedom of choice while HMOs restrict that freedom.

For the first 20 years of its existence—1960 to 1980, the FEHB Program operated effectively and without controversy. However, over the next 10 years, difficulties arose as our Nation's health care costs increased at a dramatic pace. Health care spending totalled $942.5 billion in 1993—up from $249 billion in 1980 (*see* "Report Cites 12 Percent Rise to Total of $942.5 Billion in 1993," 2 BNA Pension Reporter 25 (Jan. 3, 1994)). Consequently, by the mid-1980's, the FEHB Program, like private sector employer sponsored programs, was caught in the grips of this health care cost inflation problem. Between 1980 and 1990, FEHB Plan premiums more than tripled from $3.7 to $12.5 billion annually. See "Work Years and Personnel Costs—Executive Branch United States Government—Fiscal Year 1992" (U.S. Office of Personnel Management publication). Federal employees and annuitants confronted significant premium increases for their FEHB Plan coverage when the Open Season rolled around.

At a Subcommittee on Compensation and Employee Benefits oversight hearing held in May, 1988, Congressman Gary Ackerman reported that: On the average, FEHBP premiums have increased by approximately 31 percent this year—some plans' rates rose in excess of 70 percent—and the premium inflation is not likely to abate in the 1989 contract year. In part these premium increases reflect the failure of recent efforts to control FEHBP health care costs.

At that hearing, CNA responded to this concern with the following constructive suggestions: An objective review of FEHBP claims costs points out obvious opportunities for savings [including]: Mandatory Pre-Admission Certification and Continued Stay Review, Mandatory Case Management, Strong Preferred Provider Organizations ("PPOs"); However, under the current acquisition regulations (FEHBARs), actual disincentives for [benefit] cost containment have been put in place. The expense of reducing claims costs through utilization review and cost containment initiatives are lumped together with administrative expenses and are subject to an annual cap on administrative expenses that may be charged to the Program.

For example, this cap prohibited CNA from receiving federal contract reimbursement for over $8,000,000 in utilization review and PPO expenses incurred in 1988. Consequently, FEHB fee-for-service plans often were slow in developing managed care infrastructures, and 13 of those plans dropped out of the FEHB Program in the next three years.

In 1990, OPM, with strong Congressional and FEHB plan support, adopted the cost containment reforms that CNA, among others, had advocated at the 1988 hearing. FEHB fee-for-service plans were mandated to implement hospital utilization review, case management, and PPO programs (5 U.S.C. § 8902(n)). Those plans also were authorized to receive reimbursement for such expenses outside the annual administrative expense cap. (Such cost containment expenses, of course, remain subject to the government contract cost allowability requirements of reasonableness and allocability.)

This action successfully has stabilized FEHB fee-for-service plan premiums (and increased their benefit coverage) through a rapid expansion of managed care in

those plans. In our view, much of health care cost inflation results from certain significant defects in the health care marketplace including the lack of consumer (patient) accessible information on the quality of care and the absence of consumer cost-consciousness because the vast majority of costs are funded by third party payers. Managed care corrects these defects by, among other things, (1) Directing patients, though preferred provider organizations ("PPOs") and/or case management programs, to institutions or providers who, in return for volume, will (a) accept a negotiated price and (b) give contractual guarantees to provide only medically necessary services, and; (2) Conducting utilization review of high cost care, such as hospitalizations and surgeries, based on professional medical evaluations of overall medical necessity and the cost efficiency of the proposed treatment setting.

While the fee-for-service plan participant always retains the freedom to choose his or her own provider of care, we find that patients prefer to use providers who participate in value-added managed care systems. Managed care therefore produces an efficient and pro-competitive, payor-driven market which provides fee-for-service plan members with quality health care at an affordable cost.

PPOs currently are the most important component of the managed care infrastructure for fee-for-service plans. According to a February 14, 1994, article in *Business Insurance* (J. Geisel, "Employees Confident of PPO Savings," p. 22), Eighty-three percent of employers either agreed or strongly agreed that PPOs were effective in controlling their health care costs, according to the Foster Higgins survey. * * * Employers have good reason to believe in the ability of PPOs to control health care costs: In 1993, PPO costs rose 5.5% to an average of $3,317 per employee from $3,145 in 1992 according to the survey. That was the lowest increase of the three major types of health care plans.

However, establishing a PPO is a difficult process that is geographically specific, highly technical, and data intensive. PPOs link networks of hospitals, laboratories, physicians, and allied health care providers with health insurance plan populations in certain geographic areas. The PPO developer, which may be an insurer or another managed care organization in the fee-for-service plan context, builds such networks by contracting with health care providers to provide their services at negotiated rates in return for increased patient volume from participating health plans. These negotiated rates may include diagnostic-related group ("DRG") based rates, resource based relative value schedule ("RBRVS") rates, per diem rates, and simple percentage discounts. PPOs generate patient volume by offering participating health plan members financial incentives, such as reduced deductible or coinsurance amounts, to use network providers. Consequently, PPOs require a specific number of providers to make them easily available to employees, yet not so many as to lower volume to participating providers. Once in place, a PPO must be monitored constantly or the savings or quality of care may dissipate.

CNA has used PPOs in the MHBP since 1986. The MHBP's managed care services administrator is Private Healthcare Systems, Inc. ("PHCS"). Over the past five years, we have accelerated the development of the MHBP's PPO networks in urban, suburban, and rural areas with heavy concentrations of MHBP enrollees. We successfully have undertaken the difficult task of developing PPOs in smaller metropolitan areas such as Anniston, Alabama, and Warner Robbins, Georgia. As a result of these efforts, MHBP PPO networks now cover 75% of its nationwide enrollment. We estimate that the MHBP's managed care infrastructure saved the FEHB Program $67,300,000 in 1993 and will save it $77,000,000 in 1994.

This managed care infrastructure produces additional savings which are passed onto MHBP enrollees through increased benefit coverage levels. MHBP High Option enrollees who utilize our PPO hospitals, laboratories and physicians enjoy 100% inpatient coverage and 95% coverage of PPO-negotiated doctors charges for surgery, maternity care, and outpatient services. The enrollee is liable only for 5% coinsurance on outpatient services. Moreover, even that small coinsurance factor disappears should the enrollee (and/or covered dependents) incur $2,000 in eligible out-of-pocket expenses. Perhaps best of all from the member's perspective is the fact that there are no claims to file when a PPO network provider is used. We also are working hard to create electronic connectivity between our network providers and our claims payment office in Rockville, Maryland. This will reduce paperwork burdens on both the providers and ourselves. Now that's administrative simplicity.

PPOs depend on strong quality assurance and utilization review programs for their success. In our opinion, PHCS's quality assurance and utilization review programs are unsurpassed in the FEHB Program.

PHCS's quality assurance program logically begins at the PPO provider selection stage. PHCS selects hospitals for inclusion in our PPOs based on an analysis of statistical cost and quality information and on-site visits. PHCS selects physicians for inclusion in our PPOs through a process that verifies the physician has admitting

privileges at a PPO hospital, is licensed, and has no history of medical board disciplinary action. PHCS annually updates and reverifies its PPO hospital and physical credentialling. PHCS also monitors the practice patterns of PPO physicians through its proprietary Physician Quality Monitoring Program. PHCS's comprehensive PPO quality assurance program assures Plan members that the MHBP PPOs are directing them to well-qualified care providers.

PHCS's utilization review program reviews the medical necessity and length of stay for all hospitalizations whether or not to a PPO participating hospital.[1] Whenever medically feasible, inpatient admissions are redirected to lesser cost settings such as outpatient surgical centers. As a part of the utilization review process, PHCS screens the medical necessity of surgeries based on carefully developed protocols. PHCS focuses special attention on surgeries that may be overutilized such as hysterectomies. In this regard, we view PHCS as the patient's ombudsman—advocating that the patient review medically necessary and cost effective care. After approving a patient's length of stay, PHCS will contact the patient's doctor to make certain that the patient is discharged on time or an extension of stay is requested and approved. We are pleased to report that our utilization review program has a compliance rate of well over 90%.

In sum, we have built a comprehensive managed care infrastructure for the MHBP that fully achieves managed care's goal of providing quality care at a reasonable cost with increased benefits and no red tape for the enrollee. Moreover, the other 11 fee-for-service plans currently participating in the FEHB Program now also possess well-developed managed care infrastructures. Sixty-five per cent of federal and postal employees and annuitants are enrolled in these plans.

OPM Director James King justifiably has credited this managed care infrastructure for the FEHB Program's recent success in controlling premiums. Since 1990, FEHB premium increases have been substantially lower than private sector health insurance premium increases. See J. Glassman, "Uncle Sam's a Smart Buyer in One Area: Health Care," Washington Post, p. G1 (September 17, 1993).[2] Last September, OPM announced a 3% increase in the overall cost of FEHB Program premiums in 1994 (see Sept. 14, 1993, OPM press release). In comparison, medical care costs—as measured by the consumer price index for all urban consumers (CPI–U)—rose by 5.4% in 1993 (see "Moderation in Health Care Costs Holding as Analysts Access Outlook," 2 BNA Health Care Policy Report 174 (Jan. 3, 1994)), and employer health care benefits costs—including indemnity plan, PPO, HMO, and prescription drug, dental, and vision plan costs—rose by 8% last year according to the comprehensive A. Foster Higgins & Co. survey (see J. Geisel, "Health Plan Inflation Held to 8%" in 1993, Business Insurance, p. 1 (Feb. 14, 1994)). It is particularly noteworthy that the FEHB Program has controlled its premiums without resorting to measures such as preexisting condition limitations, waiting periods, or annuitant benefit cutbacks. About 1.5 million annuitants receive the exact same FEHB Plan coverage and rates enjoyed by younger, healthier, active employees.

The Committee will be pleased to recall that many other significant FEHB program reforms have been achieved over the last five years. For instance, at the May, 1988, FEHB Program oversight hearing, CNA also encouraged certain administrative improvements in the FEHB Program, including revision of the many antiquated enrollment, eligibility, payroll office, and OPM data directives that place enormous administrative burdens on FEHB plan carriers, underwriters and administrators. I wish to commend OPM for the significant progress that has occurred in these areas over the past five years:

Data Directives—At OPM's direction, FEHB plans will provide OPM next March with a benefit claim utilization data tape that contains detailed information by patient in a standard format. FEHB plans also are providing OPM with a standard format Demographic Data tape that contains detailed enrollment information on employees annuitants, and dependents. This data will allow OPM to track utilization trends and patterns by Plan and across the entire FEHB Program.

Enrollment—Federal payroll offices provide eligibility information to FEHB plans. CNA, on behalf of the MHBP, is working with the National Finance Center and the Department of Agriculture to automate this process. Five FEHB plans including the MHBP are participating in the OPM sponsored Automated Reconciliation pilot project. This project will simplify the process of reconciling payroll office and Plan office enrollment information. Both projects—scheduled for implementation in

[1] If the doctor is one of our PPO network providers, he is under contractual obligation to contact our utilization review unit when an MHBP member requires hospitalization. This is another way that the PPO unburdens the patient.

[2] Moreover, a significant percentage of each MHBP premium increase during this period has been attributable to preventive, basic, and catastrophic benefit increases.

1994—ultimately will be extended to all payroll offices. We are certain that these projects will improve service to Plan enrollees and also will provide additional financial safeguards to the Plans and the Government.

Congress and OPM also deserve credit for other major administrative reforms that have occurred over this same period, including the following:

CASH MANAGEMENT

Letter of Credit System—Since early 1989, FEHB fee for service Plan carriers and underwriters have used a letter of credit to access Plan subscription income held in the U.S. Treasury. Initially, carriers and underwriters could draw down funds via the letter of credit upon issuance of a benefit or administrative expense check. Congress modified this scheme in the Omnibus Reconciliation Act of 1990 ("OBRA '90"). Thus, since early 1991, carriers and underwriters are not permitted to draw down funds from the Treasury until the benefit or administrative expense check is presented for payment at the Plan's bank. Consequently, carriers and underwriters now hold a minimal amount of working capital. (Furthermore, these entities are required to segregate those FEHB Plan funds from other carrier/underwriter funds.) Thus FEHB Plan subscription income remains in the U.S. Treasury for the longest possible period of time, *see* 5 U.S.C. §8909(a); 5 C.F.R. §890.505.

Premium Tax Preemption—OBRA '90 also exempted FEHB Plan carriers, underwriters and administrators from the burden of state and municipal premium taxes effective January 1, 1991 (5 U.S.C. §8909(f)). The FEHB Program thus is treated the same as the Federal Employees Group Life Insurance Program which was exempted from premium tax levies in 1981. This measure saved the FEHB Program approximately $100 million in 1993 alone.

Administrative Expense Reductions—FEHB fee for service plans and experience rated FEHB HMO plans are reimbursed for allowable administrative expenses up to an annual cap. Until January 1, 1988, that cap was based on a percentage of paid benefits. Effective on that date, OPM established the 1987 cap as a base for the annual cap and adjusted the base only for percentage changes in Plan enrollment and inflation (CPI–U) compared to the prior year. Effective January 1, 1993, OPM negotiated reductions in those Plan administrative expense bases and eliminated automatic cap adjustments for enrollment changes.

QUALITY ASSURANCE

Correction of Deficiencies—Effective January 1, 1991, all FEHB Plan plans and underwriters must give OPM notice of "significant events" which may impact the Plan's ability to service Plan enrollees, such as disposal of material assets or labor disputes. In response to such notice, OPM is authorized to take one or more actions to protect Plan enrollees, including freezing enrollment and terminating the Plan. OPM further is authorized to take such actions without first receiving a Plan notice when it detects a material deficiency in the Plan's ability to administer its contract.

Establishment of Plan Quality Assurance Programs—Effective January 1, 1991, all FEHB Plans must maintain a quality assurance program which at a minimum includes procedures to address: accuracy and timeliness of claims adjudications; recovery of overpayments; quality and responsiveness of services to Plan enrollees and OPM; and detection and recovery of fraudulent claims.

Each FEHB Plan is required to provide OPM with a copy of their quality assurance program. OPM may order correction of deficiencies in those programs. Furthermore, effective January 1, 1994, FEHB Plan must meet OPM-specified quality assurance standards for claims adjudications, recovery of overpayments, claims audits, and timeliness of responding to written and telephonic inquiries.

Alternative Dispute Resolution—OPM continues to operate an effective FEHB disputed claim resolution procedure pursuant to 5 U.S.C. §8902(j) and 5 C.F.R. §890.105. The federal courts now recognize that FEHB enrollees must exhaust this procedure before bringing a lawsuit based on a benefits claim. This dispute resolution process has reduced FEHB plan claims litigation because Plan enrollees generally are satisfied with the fairness of OPM's review decisions.

Fraud and Abuse Prevention—At Congress' direction, FEHB Plans generally will not cover charges for services and supplies rendered by providers who are debarred or suspended from the Medicare program. OPM has expanded this rule to claims for services and supplies rendered by providers who have been debarred or suspended from any other federal program such as Medicaid or CHAMPUS. OPM's Office of Inspector General also has created a unit for investigating FEHB Program fraudulent claims activity and has established a fraud and abuse hotline.

The Federal Government, taxpayers and the federal and postal workforces are the deserving beneficiaries of this successful reform process which was funded with millions in Government and employee contributions. The 35 year old FEHB Program is justifiably recognized by President Clinton, First Lady Hillary Rodham Clinton and other national leaders, including the Chairman, to be the working paradigm for consumer choice, universal access, competition, and managed care—the key elements of the President's proposal.

Thus, in his recent State of the Union address, President Clinton praised the FEHB Program as "providing those of us in Government service with terrific health care benefits at reasonable cost." He went on to say that "[w]e have health care that's always there. I think we need to give every hard-working, taxpaying American the same health care security that they have already given to us."

Paradoxically, however, the Health Security Act would abolish the FEHB Program.[3] OPM Director King stated before this Committee on November 8, 1993, that our analysis leads to the opposite conclusion. Abolition of the FEHB Program will lose, not preserve, the value of the considerable taxpayer investments in the FEHB Program's managed care infrastructure and the other successful reforms which are summarized above. Furthermore, federal employees and annuitants unquestionably will experience a "significant change" if they are required to purchase basic coverage under an accountable health plan ("AHP") of the regional alliance in which they reside. That coverage would differ from their current FEHB Plan coverage in the following material respects:

1. The Administration concedes that the Health Security Act's core benefit packages are less generous than FEHB Plan coverage by authorizing OPM to establish supplemental plans that "reflect the overall level of benefits generally afforded under FEHBP (as last in effect)" (Act, § 8203(f)(1)(B)). Sixty-five percent of FEHB Plan participants currently are enrolled in fee-for-service plans. If these workers elected coverage under the Administration's "higher cost sharing," or fee-for-service, option, they would be liable for 20% of all covered charges, including inpatient hospital charges, up to an individual out-of-pocket limit of $1500 and a family limit of $3000 (Act, § 1135). That is a $1000 copayment on a $5000 hospital bill.

In contrast, the MHBP's High Option covers 100% of inpatient hospital bills after a $125 deductible that is waived if the patient utilizes a preferred provider organization ("PPO") hospital. The Blue Cross Blue Shield Government-wide plan and several smaller fee-for-service plans offer the same level of hospital coverage. All other FEHB fee-for-service plans currently cover 100% of room and board charges and impose 5% to 20% coinsurance on ancillary charges, which is reduced or waived if the patient is admitted to a PPO participating hospital. This means that all FEHB plan enrollees will suffer a serious hospital benefit cutback should their coverage be shifted to the regional alliances.

2. FEHB plan coverage provides uniform benefits and premium rates to enrollees nationwide. That uniformity would evaporate under the Health Security Act. State governments could modify the AHP coverage levels in their regional alliances or could establish single payer plans (see Act §§ 1203(e), 1221). Furthermore, due to community rating, premiums for the same AHP benefit package will vary from one regional alliance to another depending upon demographic and other factors. Regional alliances in certain geographic areas will charge above national average premiums, and the others will charge below national average premiums. For example, the Wyatt Company, a health care actuarial consulting firm, recently estimated that annual premiums for individual coverage under the Health Security Act would be lowest in Nebraska at $1,472 (or 64% of Wyatt's estimate of the average premium) and highest in the District of Columbia at $2,917 (or 128% of Wyatt's estimate of the average premium) (see "Wyatt Model Predicts Higher Cost for Employers Under Clinton Proposal," 2 "BNA Health Care Policy Report," pp. 238–239 (Feb. 7, 1994)).

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[3] In fact, the FEHB Program is the only Federal health program that the Health Security Act would disband. CHAMPUS and the Department of Veterans Affairs, among others, would be allowed the discretion to decide whether, and on what basis, to merge their programs with the regional alliances. Ironically, however, the FEHB Program is the only Federal health program that successfully has controlled its benefit costs without extensive government-imposed price controls like DRGs that shift those costs to the private sector. In fact, the current CHAMPUS reform initiative seeks to model CHAMPUS upon the FEHB Program.

Compared to insurance programs available to many Americans today, the FEHBP is a superior program because it exhibits many of the principles that the President has identified as the foundation of the Health Security Act. The FEHBP operates much like the regional alliances that the President is proposing, so federal employees should not experience a significant change when they move into the new system. Those features that have made the FEHBP such a good program are preserved and enhanced under the Health Security Act and other desirable features have been added.

This study suggests that recent locality pay increases in urban areas may be eaten up by higher regional alliance premiums. Similarly, workers in rural areas with few health care resources may need locality pay increases to cover high regional alliance premiums.

3. FEHB Plans have encouraged their members to use participating PPO hospitals and physicians through financial incentives, such as decreased or waived patient deductibles and/or coinsurance. As a result, FEHB Plan enrollees now have developed strong relationships with doctors in these managed care networks. The Health Security Act would eliminate the FEHB Program's extensive managed care infrastructure and would disrupt these cost effective FEHB Plan PPO participating doctor/patient relationships. Congresswoman Eleanor Holmes Norton has eloquently articulated the problems that dismantling the FEHB Program would create for the District of Columbia. The same problems unfortunately would arise as well in other areas of the country with heavy concentrations of federal employees.

OPM Director King nevertheless contends that federal and postal employees will "fare well" in the regional alliances because the Health Security Act offers "other desirable features." He points out that the Government contribution will be higher than the current contribution under the FEHB Act and that the supplemental plans will fill any coverage gaps resulting from the loss of FEHB Plan coverage. Our research, however, calls into question the desirability of these features.

A change in the Government contribution formula under the Health Security Act does *not* translate into increased compensation for all employees. The Health Security Act creates separate formulas for employer and employee contributions. The employee contribution under the Health Security Act is essentially the difference between the selected AHP premium and the "alliance credit amount" (Act, §6101(b)). The Congressional Budget Office's "Analysis of the Administration's Health Proposal" (Feb. 8, 1994, hereafter "CBO Analysis") explains (p. 9) that:

> Every individual and family who enrolls in a plan offered by a regional alliance would be assigned at "alliance credit amount" that would equal 80 percent of the weighted average premium in that alliance for that type of family. * * *

Therefore, to determine the credit amount we need to know "the weighted average premium in the alliance."

Both the Administration and the CBO, among others, have estimated Health Security Act premiums assuming it were in effect in 1994. The Administration estimates that the higher cost sharing plan would cost $1,923 for single coverage and $4,360 for family coverage. The CBO Analysis states that:

The estimated total premiums * * * in 1994 for the four types of policies specified in the Administration's proposal are as follows:

	Total premium
Single person	$2,100
Married couple	4,200
One-parent family	4,095
Two-parent family	5,565

The Wyatt Company also weighed in with higher estimates than the Administration's—$2,285 for single coverage and $5,155 for family coverage (see 2 "BNA Health Care Policy Report," pp. 238–239).

These estimates vary principally due to differing opinions on the increase in overall health care service utilization as the previously uninsured receive coverage and the underinsured receive enhanced benefits. (It also must be recalled that—unlike the FEHB Program—these premiums would vary by regional alliance because of differences in demographics and the cost of providing care.) For purposes of our analysis, we accept the accuracy of the CBO estimates.

Based on that assumption, the alliance credit amounts would be as follows:

	Total premium	.80 = credit amount
Person	$2,100	$1,680
Married couple	4,200	3,360
One-parent family	4,095	3,276
Two-parent family	5,565	4,452

The CBO Analysis (p. 9) explains that under the Health Security Act "the family's portion of the premium would be the difference between the premium for the plan selected by the family and the alliance credit amount, subject to various other adjustments, including subsidies [and surcharges, for example, the family collection shortfall add-on]." We can estimate the employee contribution under the Health Security Act simply by subtracting the alliance premium credit amount from the CBO premium estimate as follows:

	Employee contribution
Single person	$420
Married couple	840
One-parent family	819
Two-parent family	1,113

The employee contribution for FEHB Plan coverage is the difference between the selected FEHB Plan premium and the statutory Government contribution. The FEHB Act sets the Government contribution at 60% of the Big Six average capped at 75% of the Plan's rate (5 U.S.C. §8906). The 1994 total annual premiums and employee contributions for MHBP High Option and Blue Cross Blue Shield FEP Standard Option coverage are as follows:

	Total premium	Employee share
MHBP high option:		
Self only	$2,008	$502
Self and family	4,469	1,117
BC/BS FEP standard option:		
Self only	2,180	545
Self and family	4,860	1,215

The majority of FEHB Plan enrollees are concentrated in these two plans. Moreover, only 10% of the comprehensive medical plans participating in the FEHB Program offer rates lower than Blue Cross Standard Option or the MHBP High Option, which together have roughly 2,000,000 of the 4,000,000 federal and postal enrollees.

We have found it useful to compare the current employee share for these popular FEHB Plans with the estimated employee share of CBO estimated premium under the Health Security Act ("HSA") as follows:

	Employee share		Premium reduction under HSA
	MHBP high option	Under HSA	
Self only	$502	$420	$82
Married couple	1,117	840	277
One parent family	1,117	819	298
Two parent family	1,117	1,113	4

	BC/BS FEP standard option	Under HSA	Premium reduction
Self only	$545	$420	$125
Married couple	1,215	840	375
One parent family	1,215	819	396
Two parent family	1,215	1,113	102

After federal and state income and Social Security/Medicare tax withholdings,[4] the extra monthly take-home pay under the Health Security Act amounts to perhaps:

$5.12 for MHBP High Option enrollees with self only coverage;

$18.00 for MHBP High Option enrollees with family coverage who are part of a married couple or one parent families;

$7.81 for BC/BS FEP Standard Option enrollees with self only coverage; and

$24.37 for BC/BS FEP Standard Option enrollees with family coverage who are part of a married couple or one parent families; and

[4] The Health Security Act would prohibit the payment of premiums with pre-tax dollars through the use of I.R.C. § 125 cafeteria plans (see CBO Analysis, p. 13).

$6.37 for BC/BS FEP Standard Option enrollees who are in two parent families.

Two parent families currently covered under the MHBP High Option would see no change at all.

In return for limited, if any, premium reductions, the federal worker must assume a new and substantial financial risk to retain the freedom of choice associated with a fee for service plan in the regional alliance—the 20% coinsurance obligation imposed on inpatient and outpatient care under the Administration's high cost sharing option. If a worker or a dependent child is hospitalized even briefly, that coinsurance obligation would quickly run up to $1,000 or more and dwarf any extra take home pay resulting from the increased Government contribution. Even without such a hospitalization, the federal worker would have to use the extra pay and then some to pay for supplemental plan coverage to replace, among other things, valuable dental coverage currently available from the MHBP High Option and Blue Cross FEP Standard Option, among other FEHB plans.

Furthermore, in our view that supplemental plan proposal is fatally flawed on two counts. First, it is directly contrary to the President's goal of simplicity. Under the Health Security Act, an average Federal employee would need to enroll in a regional alliance, a supplemental health benefits policy (which would replace for example FEHBP dental coverage), and a cost sharing policy (to reimburse additional out-of-pocket expenses) to duplicate the same level of coverage which that employee previously had enjoyed under one FEHB Plan (see Act §§ 1422, 1423, 8203(b)(3), (c)(2), (e), (f)). Dividing current FEHB Plan coverage into two or three separately administered parts will create administrative inefficiencies for the various plans, with attendant extra costs and confusion for the employees. Moreover, the triple premium payment for regional alliance, supplemental, and cost sharing coverage for any group necessarily will overshadow the employee contribution for coverage under the MHBP or the BC/BS Standard Option.

Second, the supplemental plan proposal is directly contrary to the group insurance principles that have proven so successful for the FEHB Program. At its root, group health insurance is meant to be an economical way to provide individuals within a group with protection against financial disaster due to large medical care expenses. It is economical when the experience of a large group with a sufficient variety of personal demographic characteristics (age, sex, lifestyle, income) is pooled to ensure an acceptable level of medical care expenses (or claims cost) as a group. When these costs are spread out as bi-weekly contributions from all members of the group, they are affordable. For individuals who experience high usage of medical care, the resultant individual cost realistically would not be manageable without the collective funding afforded by the group.

The MHBP High Option and the Blue Cross Standard Option plans are prime examples of such risk pools. Both plans cover large groups that reflect the demographic diversity of our Nation. However, the supplemental plans proposal would fissure these risk pools by encouraging adverse selection of risks. People who pay for supplemental coverage generally expect that it will pay off, and those who do not need the coverage—the healthier risks—will not purchase it. Such adverse selection results in a supplemental plan risk pool which lacks the diversity of demographic characteristics necessary to spread costs equitably. As a result, the people who need supplemental coverage may find themselves priced out of the market. In particular, let us consider the elderly non-Medicare eligible annuitants whom the Administration would place in a separate pool for supplemental coverage (see Act § 8203(c)(2)). We estimate that the average non-Medicare eligible annuitant incurs at least twice the claims costs of an active employee. Under the FEHB Program, these senior citizens enjoy the same rates and benefits as all other Federal employees and annuitants because of the existence of one risk pool for each plan or plan option. Obviously, this group would see its premiums skyrocket if it is left to fend for itself. Similar problems may beset the FEHB Medicare supplemental plan and the mini-FEHB programs for overseas and temporary federal employees that OPM would establish and administer under the Administration's reform proposal (see Act §§ 8203, 8204). Accordingly, we expect that the supplemental plan proposal ultimately will fail.

For all of these reasons, it is our view that federal and postal employees would not "fare well" under the Health Security Act. We further hold the option that abolition of the FEHB Program is detrimental to the interests of the Federal Government as an employer for several reasons. As this Committee is aware, the Health Security Act generally caps the premium obligation of an employer participating in the regional alliance system at 7.9% of its wage base. The Health Security Act (§ 6123(b)(2)(A)) does not extend this 7.9% cap to governmental employers until the year 2002—five years after the FEHB Program is scheduled to be dissolved. This

may not appear to be a problem because the Government contribution to the FEHB Program is significantly less than 7.9% of the wage base. In Fiscal Year 1992, the Government contribution totalled $6.7 billion or 6.3% of its $105.5 billion wage base. See "Work Years and Personnel Costs—Executive Branch United States Government—Fiscal Year 1992" (U.S. Office of Personnel Management publication).[5] However, the Health Security Act has a brand new employer contribution formula that is based on currently unknown average weighted premiums for each regional alliance. See CBO Analysis, pp. 9, 27–33; 2 "BNA Health Care Policy Report," pp. 235–36 (Feb. 7, 1994). When the dust settles in 1998 (assuming for the moment that the FEHBP is disbanded), we may find that the Government contribution under the Health Security Act is more than 6.3% or even 7.9% of the wage base. Undoubtedly, such a cost spiral would put pressure on Congress to reduce other elements of the federal employee compensation package. Recent news reports indicate that State Governments such as New York and California and the Government Financial Officers Association now are joining the chorus of objectors to this obvious inequity to governmental employers. See R. Pear, "Cuomo Sees Clinton's Health Plan Hurting New York Workers," New York Times, p. A14 (Jan. 11, 1994); "GFOA Panel Adopts Health Care Policy to Focus on 'Priority' for Public Employees," 2 "BNA Health Care Policy Report" 221 (Feb. 7, 1994).

It also is troubling that the Health Security Act would cause Congress to delegate its constitutional prerogative over federal pay and benefits to the state governments and their regional alliance bureaucracies. As you know, OPM currently possesses Congressionally-delegated authority to negotiate benefits and rates for the Government and to take necessary actions to protect the welfare of the federal workforce. OPM successfully operates the FEHB Program with fewer employees (approximately 140) and less regulation than any other Government health plan. It is puzzling to say the least that the Health Security Act targets the FEHB Program alone for destruction.

The Administration evidently perceives a political need to transfer the 10,000,000 FEHB Program participants to the regional alliances no matter how adverse the consequences for the U.S. Government or its workforce. As we understand their logic, if the Government isn't willing to place its employees in mandatory alliances then why should private sector employers? The problem lies not so much in the logic as in the concept of these mandatory regional alliances under the Health Security Act. All private sector employers with under 5,000 employees and all governmental employers would be required to participate in these huge purchasing alliances. Even assuming for the sake of argument that all eligible private sector employers with 5,000 or more employees opt to establish corporate alliances, the regional alliances would include 78 to 88 per cent of all non-military and non-Medicare eligible individuals.[6] Under current anti-trust laws, the courts consider market share over 60% to represent anti-competitive nonopsonistic power that can reduce prices below competitive levels and stifle innovation.

We therefore must focus our attention on producing a health care reform measure that strengthens competition in the health care market. Preserving the FEHB Program would be a giant step towards the accomplishment of that goal. Because the U.S. Government is the Nation's single largest employer, Congress can, and does, use the FEHB program as a pro-competitive force that sets the national health and human resources priorities for private sector employers. Thus, for example, the FEHB Program currently demonstrates to the private sector that the President's universal access, portability, administrative simplicity, and preventive care goals are achievable. In our view, the FEHB Program is the best mechanism for setting the pace of health care reform particularly over the next 5 to 10 year period.

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[5] In contrast, the U.S. Chamber of Commerce has reported that the private sector employer's share of medical and medically related costs represented 10.3% of payroll in 1992. The Chamber surveyed 1,103 firms representing a cross-section of firms in terms of industries, geography and size (see "BNA Compensation & Benefits Guide," p. 2 (Jan. 19, 1994)).

[6] This projection is understated because the CBO projects that due to the significant disadvantages associated with establishing single employer corporate alliances, those alliances initially will cover 23% of eligible employees and after 2001 will cover only 11% of that group (CBO Analysis, pp. 30–31).

If purchasing alliances were limited to employers with 100 or fewer employees, they would cover from 40 to 54 percent of all non-Medicare and non-military individuals. This is certainly an adequate amount of market power to obtain favorable premium rates from AHPs.

The statistical variations in these projections result from the fact that families with workers at both regional and corporate alliance employers may elect coverage from either employer.

Accordingly, rather than abolishing the FEHB Program, any health care reform measure ultimately enacted should amend the FEHB Act for the purpose of fostering the further expansion of managed care/competition within the FEHB Program and achieving universal coverage:

(a) The FEHB Act should allow FEHB plans the flexibility to offer more than two options; the current two option maximum restricts fee-for-service plan opportunities to innovate with advanced managed care arrangements such as primary care physician networks and exclusive provider organizations ("EPO");

(b) The FEHB Act should require FEHB Plan managed care systems to collect data on provider practice patterns to assist network physicians in comparing their practice patterns to those of peers;

(c) The FEHB Act should require OPM to reward Plan usage of electronic data interchanges ("EDI") to make eligibility determinations and process claims and benefit payments;

(d) The FEHB Act should require FEHB plans to accept a nationally uniform claim form;

(e) The FEHB Act should require OPM to continue the development of better eligibility systems;

(f) The FEHB Act should permit joint ventures between fee-for-service plans and more controlled managed care models; and

(g) The FEHB Act should collect data on the use of preventive care and screening services for the purpose of validating their efficiency through outcomes research.

OPM should be required periodically to analyze for this Committee the social policy propriety and cost-effectiveness of managed competition in the FEHB Program.

This approach would enable the FEHB Program to continue pacing change in the health care system and would maintain the integrity of the federal and postal employees' benefits packages. The FEHB Program thus would remain a pro-active (and re-active) value-added presence in the evaluation of the Nation's health care system, thereby preserving the taxpayer's substantial investment in this successful system.

Finally, although we believe that the FEHB Program should and ultimately will survive, we must comment on the transition provisions of the Health Security Act. We applaud the successful efforts of the Chairman and the Committee members to convince the White House to keep the FEHB Program intact at least until all regional alliances have been established. We agree with you and OPM Director King that the piecemeal dissolution of the FEHB Program contemplated by the Administration's initial reform proposal spelled serious trouble both for FEHB plan enrollees and for OPM. Consequently, we remain concerned by the fact that the Health Security Act would terminate the FEHB Program on December 31, 1997, regardless of whether the January 1, 1998, date for full implementation of all regional alliances has slipped. In our opinion, this provision requires greater flexibility.

The CBO Analysis cautions the Congress and the general public that the Health Security Act would impose extraordinary administrative obligations on the regional alliances. According to the CBO Analysis (p. 70):

> Any one of the [regional alliance's functions] could be a major undertaking for an existing agency with some experience, let alone for a new agency that would have to perform them all. Some regional alliances might succeed very well; others might be overwhelmed by these tasks, especially in their early years of operation.

Adding federal employees and annuitants on a fixed date will further complicate the state government's difficult responsibility of making the regional alliances operational. Moreover, the Health Security Act provides that if the Department of Health and Human Services finds it necessary to assume the responsibilities of a nonexistent or nonfunctioning regional alliance, it may assess a 15% premium surcharge to AHP members in the alliance (*see* CBO Analysis, p. 15). Consequently, if political forces dictate that the FEHB Program must be dissolved, then Congress must replace a proven product—the FEHB Program—with a proven product. To this end, the Health Security Act should be amended to provide that in no event would the FEHB Program terminate before December 31 of the year in which all the regional alliances have become fully and competently operational.

I also wish to point out that in the event the FEHB Program is disbanded, over three million Federal employees would be required to positively reenroll in the regional health alliances to which their coverage is transferred. In 1989, when Aetna withdrew from the FEHB Program, over 15% of its enrollees failed to positively reenroll in other FEHB plans although OPM sent them four certified letters reminding them of their obligation to do so. If past experience is any guide, the positive reenrollment requirement of the President's reform proposal may cause many Federal and postal employees and annuitants—particularly those elderly annuitants

without Medicare coverage—to receive default coverage under the lowest cost plan in the regional alliance. Furthermore, Section 1323(i) of the Act would penalize such people by charging them *twice* the regular premium for the entire year unless they can show good cause for failing to make a timely election.

If federal and postal employees and annuitants are placed in the regional alliances, they would be faced with a choice of HMOs and fee-for-service plans that are camouflaged HMOs. The consensus of outside opinion is that the Health Security Act's goal is to drive citizens into these organizations which tightly control a patient's access to health care resources. This viewpoint apparently is confirmed by the First Lady's efforts last week to court HMO industry support for the Health Security Act. *See* D. Priest, "First Lady Courts HMO Support," *Washington Post,* p. A6 (Feb. 16, 1994).

It is time for someone to point out that the HMOs are not charitable organizations and to challenge the perception that HMOs are the most cost-effective health care delivery systems. I repeat that only 20 HMOs currently participating in the FEHB program have rates that are lower than the MHBP's. I also encourage the Committee to examine who benefits from the presumed cost effectiveness of HMOs. Interstudy, an HMO research group, recently reported that 86% of 374 reporting HMOs earned a profit in fiscal 1992. *See* "Increase in premiums and enrollment mean more profits for HMOs," 11 *Business & Health* 22 (Oct. 1993). Those HMO profit margins are a big hit in the investment community. *See* R. Winslow, "Industry Focus: HMOs are Expected to Deliver Strong Profit Growth, *Wall Street Journal* p. B4 (Jan. 17, 1994):

> Analysts expect HMOs to report earnings gains well over 20%—and in one case a 73% jump—for the quarter ended Dec. 31, the result of surging enrollments and moderating health care costs. * * *
>
> Analysts expect U.S. Healthcare, Inc. to post a 33% earnings increase.

On November 2, 1993, Saloman Brothers released an investment report on U.S. Healthcare, a large for-profit HMO, which states in pertinent part that

> U.S. Healthcare, Inc., had third quarter 1993 earnings of $0.72 versus $0.44 reported a year ago. The company saw healthy margins and enrollment growth. *The key medical loss ratio, the proportion of premiums consumed by medical expenses, fell to 72.1% from 78.3% a year ago.*

(Emphasis added, report available on Dow Jones News Service.) In contrast, FEHB Program fee-for-service plans set their rates so that over 90% of subscription income is returned to enrollees in the form of benefit payments.

Thereafter, on February 7, 1994, U.S. Healthcare reported 1993 net income of $299,657,000 on revenues of $2,645,235,000—that's over 11% of premiums (press release available on Dow Jones New Service). A FEHB fee-for-service plan with comparable subscription income would receive a service charge/profit of approximately $15,000,000 which is only 0.6% of premiums.[7] Moreover, FEHB fee-for-service plans return their benefit cost savings to the Government and their members in the form of reduced rates and increased benefits—not to shareholders. Is it any wonder then that a California jury recently brought back an $89,000,000 verdict against a California HMO for placing its profits over the health care of its enrollee? *See* C. Woolsey, "Jury Hits HMO for Coverage Denial," *Business Insurance,* p. 1 (Jan. 3, 1994).

For these reasons, CNA urges that if the FEHB Program must be abolished for political reasons, federal workers be protected by allowing existing FEHB fee-for-service plans which qualify as AHPs to enter into the regional alliances with their current enrollment intact. These plans then would become openended, and federal employees would be allowed to opt out to another plan in the first regional alliance open season. These transition method permits some familiarity, continuity, and stability while the federal workforce moves from the FEHB Program to the regional alliances. It also puts to use the managed care infrastructure that the Federal Government and FEHB Program enrollees already have purchased.

Mr. Chairman, CNA thanks you for holding these hearings and for allowing me to present CNA's viewpoint on the crucial issue of health care reform and the importance of preserving the FEHB Program as part of that effort. We look forward to

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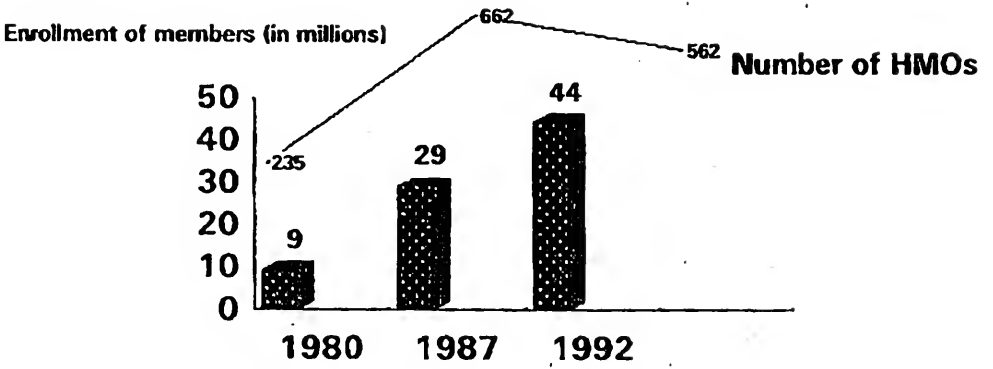
[7] FEHB fee-for-service plans receive only that portion of their subscription income which is necessary to reimburse benefits, allowable administrative expenses under FAR cost principles, and a negotiated service charge, which, as a general rule, ranges from .5 to .7% of paid benefits and administrative expenses (48 C.F.R. §1615.905). Plan reserves remain in the U.S. Treasury.

In contrast, community rated HMO's in the FEHB program are not subject to these government contract accounting strictures. Plan subscription income is paid monthly to the HMO which may use the money for any purpose which is desires. The FAR cost principles are not applicable to these HMO's. This permits them to recoup advertising expenses (which are unallowable expenses for fee-for-service plans) and to enjoy higher service charges profit than fee-for-service plans.

working with you and your colleagues on the Committee on the provisions of the Health Security Act that affect the federal workforce.

HMO Growth: Enrollment



* No. of HMOs doubled and no. of enrollees increased 400% from 1980-1992
* Slight decline in no. of HMOs from 1987-1992 due to increased competition, mergers and acquisitions

Source: HCIA data (1993)

HMO PROFITABILITY

Profitability of HMOs in 1991

* 76% Of The Nation's 578 HMOs
* 95% Of All The Network Model HMOs
* 100% Of All Large HMOs Operating 1-2 Years

HMO PROFITABILITY

DIFFERENCES IN SMALL vs. LARGE HMOs in 1991

	Small (<50,000 Enrollees)	Large (>50,000 Enrollees)
Profitability in 1991	Estimated 73%	Estimated 89%
Asset per Member Increased in 1991		
	6.5% Among All Model Types	8% Among All Types
	21% Increase For Staff HMOs	13% Increase For IPAs
Overall Return On Assets in 1991 (Based On Gross Income)		
	7% Among All Model Types	10% Among All Types
	9% For Network & Staff Models	14% For IPA Models

Source: Marion Merrell Dow Managed Care Digest 1992

HMO PROFITABILITY

HMO Industry Continues to Show Signs of Improvement in 1992

	1990	1991	1992
The Number of Profitable HMOs Increased	74%	76%	78%
The Median Profit Margin Increased		2.13%	2.35%

Attributed to a Reduction in Administrative Expenses and a Reduction in Hospital and Medical Expenses as a Percent of Total Revenues

Source: HCIA, Inc. (1993)

PREPARED STATEMENT OF MARION S. RAMEY, EXECUTIVE DIRECTOR, SPECIAL AGENTS MUTUAL BENEFIT ASSOCIATION

Chairman Clay, I thank you and the other members of the Committee for this opportunity to present the views of the Special Agents Mutual Benefit Association ("SAMBA") on H.R. 3600, the Health Security Act of 1993. SAMBA is an employee organization which was established in 1948 to promote the welfare of Federal Bureau of Investigation employees and which, since that time, has opened its membership to include other federal law enforcement agency employees as well. Since the Federal Employees Health Benefits ("FEHB") Program's inception in 1960, SAMBA has sponsored the SAMBA Health Benefit Plan ("SAMBA Plan"), which currently provides comprehensive fee-for-service health benefits coverage to over 20,000 employees and retirees of various federal law enforcement agencies worldwide. Although supportive of many of the goals which the President's proposal embraces, SAMBA firmly believes that one of the recommended methods of achieving that proposal's goals—the dismantling of the FEHB Program—is unwarranted, unnecessary, and a severe detriment to federal employees, since costs would increase and benefits would decrease.

There can be no question that over time the FEHB Program has proven capable of providing over 10 million federal employees and annuitants with access to quality health care at a reasonable cost. On this point, the Administration, Congress, and SAMBA appear to agree. As noted in an article which appeared in the January 3, 1994, *Federal Times,* First Lady Hillary Rodham Clinton testified before Congress that the FEHB Program is "a good model" for health reform. Likewise, the U.S. Office of Personnel Management ("OPM") announced in a September 14, 1993, press release that in 1994 total FEHB Program premium costs would increase by only 3%, that 40% of FEHB Program enrollees would see premium decreases, and that a large number would receive increased coverage for preventive care. Not only is that 3% premium increase roughly equivalent to the current general rate of inflation, it is significantly less than the current inflationary trend for health care services. Considering that many SAMBA Plan enrollees are at a greater risk of suffering grievous physical harm due to the dangers inherent in their profession, SAMBA is justifiably proud of the fact that the slight increase in the SAMBA Plan's 1994 premium costs is less than that of the FEHB Program as a whole. SAMBA likewise is proud of the fact that it has been able to limit these cost increases while simultaneously offering a very comprehensive and reasonably-priced plan which, like all FEHB Program plans, incorporates the key elements of the President's proposal, namely guaranteed coverage for eligible members regardless of health status, annual choice of coverage level, and the absence of pre-existing condition limitations.

SAMBA cannot comprehend why the Health Security Act proposes disbanding the FEHB Program, the only federal health program that has successfully controlled its benefit costs without extensive government-imposed price controls. This inequity is made even more apparent by the fact that the Act preserves for every other federal health program—including CHAMPUS, whose current reform initiative is specifically modeled on the FEHB Program—the discretion to decide whether, and on what terms, they will merge their health programs into the regional alliances. It seems only sensible to SAMBA that the President's proposal should strive to preserve those elements of our national health care delivery system which have proven effective, while improving, or where necessary eliminating, those which have not. To dismantle a proven commodity such as the FEHB Program, as the Health Security Act proposes doing, defies logic.

Why, then, has the Administration singled out the FEHB Program for disparate treatment? The answer, quite simply, is that the Administration harbors the political concern, which HHS Assistant Secretary Judith Feder expressed to this Committee in her November 8, 1993, testimony, that it must transfer federal employees and annuitants to the regional alliance system in order to eliminate the public perception that federal workers receive better compensation and benefits than other Americans.

Even if that perception were true (and SAMBA is not convinced that it is), the Administration's response should not be to reduce the benefits available to federal employees while increasing their cost, but to increase the benefits available to the rest of the country while reducing their cost. After reviewing the benefits and financing provisions of the Health Security Act, it is SAMBA's opinion that all federal employees, including those currently enrolled in the SAMBA Plan, will be ill-served if the FEHB Program is disbanded and they are forced to join a regional alliance. For this reason, it is our opinion that the Administration's plan to abolish the FEHB Program expresses a considerable disregard for the unique public service which

SAMBA's members provide, and generally threatens the welfare of the 10 million plus people currently enrolled in the FEHB Program.

As with any other organization, SAMBA's principal concern is how its members will be affected if the Administration's proposal is enacted. To that end, we have scrutinized OPM Director King's statement before this Committee last November that "FEHBP enrollees will fare well under the Health Security Act," and have concluded, with great regret, that his statement almost certainly will be found wanting by our membership if put to the test.

As I indicated previously, it is self-evident that federal law enforcement agency employees face a substantially greater risk of physical harm than do almost all other federal employees. When it comes to health care coverage, then, the greatest concern these individuals have is to limit the extent to which they and their families may be exposed to potentially catastrophic health care costs should they suffer a crippling injury. Although the Health Security Act addresses this problem, the solution which it proposes does not match the protection which the SAMBA Plan currently affords them. Therefore, SAMBA Plan enrollees will not be among those FEHB Program members who will "fare well" if the Administration's proposal is enacted.

For example, a current SAMBA Plan member who elected coverage under the more generous "higher cost sharing," or fee-for-service, option in the President's proposal would be liable, after satisfying a $200 deductible, for 20% of all covered charges (including inpatient hospital charges) up to a limit on out-of-pocket costs of $1,500 per individual and $3,000 per family. In other words, on a $5,000 hospital bill, the member would be liable for a $1,160 copayment (the $200 deductible, plus 20% of the $4,800 balance).

In comparison, a SAMBA Plan member who utilizes one of our Preferred Provide Organization ("PPO") hospitals is covered for *100%* of all inpatient hospital charges *with no deductible,* the same level of hospital coverage offered under the Government-wide Blue Cross Service Benefit Plan and the larger FEHB Program fee-for-service plans. In other words, the member would come out a full $1,160 ahead under the SAMBA Plan compared to the President's proposal. In fact, SAMBA Plan members who *don't* use PPO hospitals still fare better than they would under the Administration's proposal: the SAMBA Plan pays *100%* of room and board charges and *85%* of remaining covered charges for non-PPO hospitalizations, *without a deductible,* and subject to a limit on out-of-pocket expenses of $1,500 per individual and $2,500 per family. In other words, even in the worst case scenario SAMBA Plan members come out $635 ahead on the same $5,000 hospital bill (the 15% copayment on approximately 7/10 of the hospital bill is $525). In light of the fact that all of the other FEHB Program fee-for-service plans provide roughly equivalent inpatient hospital coverage, it is no exaggeration to say that, if forced to join a regional alliance, millions of FEHB Program members will suffer a significant reduction in hospital benefits.

A review of the Act's surgical benefits dictates a similar conclusion. Whereas under the fee-for-service option of the Administration's proposal a current SAMBA Plan member would be liable for the same $200 deductible and 20% copayment on a surgery bill, the SAMBA Plan currently pays *100%* of covered surgery charges *with no deductible* if the member uses a PPO provider, and 85% of reasonable and customary charges after a $250 deductible if the member does not. Indeed, all of the other FEHB Program fee-for-service plans that offer a PPO option, and even some that don't, pay more than 80% of reasonable and customary charges for surgical services under certain circumstances.

Evn the prescription drug coverage which the Administration has trumpeted as one of the Health Security Act's most generous benefits falls well short of the prescription drug coverage currently offered under the SAMBA Plan. If a current SAMBA Plan member elected coverage under the fee-for-service option of the President's proposal, he would have to satisfy a $250 calendar year deductible before he would be eligible for prescription drug benefits, after which he would be liable for a 20% copayment each time he filled a prescription. In contrast, current SAMBA Plan members can fill 90-day prescriptions by mail order may making an $8 copayment, or 30-day prescriptions at their local pharmacy by making a $12 copayment. They do not need to satisfy a deductible to qualify for these benefits, nor are the benefits subject to an annual maximum. In other words, a current SAMBA Plan member could fill *more than 20 prescriptions* for the same $250 it would take him to satisfy the *deductible* he would be responsible for under the Act. Moreover, the prescription drug benefits for which the member would be eligible after he had satisfied that deductible still would not equal the prescription drug benefits for which he is currently eligible under the SAMBA Plan.

In short, the coverage offered under the Health Security Act fails to measure up to that currently available to most federal employees, including SAMBA Plan members. That being the case, any reduction in premium costs which SAMBA Plan members may experience due to an increased Government contribution toward their purchase of coverage from a regional alliance (and SAMBA does not foresee such reductions as being likely) is almost guaranteed to be swallowed up by the increased out-of-pocket expenses and copayment liabilities to which they will be exposed under the President's proposal.

The coverage which the SAMBA Plan makes available to federal law enforcement employees surpasses that proposed under the Administration's fee-for-service plan in most key areas largely because in recent years the SAMBA Plan has used a sizable portion of its assets to implement various benefit cost containment initiatives. Even before the 1990 directive from Congress and OPM that FEHB fee-for-service plans take such cost containment measures, the SAMBA Plan had begun to invest Government and employee contributions in the creation of a nationwide infrastructure of PPO networks, and in a hospital utilization review program. Currently, SAMBA realizes over $8 in benefit cost savings for each dollar which it invest in those cost containment initiatives.

The SAMBA Plan, like its FEHB Plan brethren, has used financial incentives such as decreased or waived patient deductibles or coinsurance to encourage its members to use these PPO networks, in which hospitals and providers accept reduced benefits in return for an expected increase in the number of patients they will treat. As a result, significant numbers of FEHB Program members, including those currently enrolled in the SAMBA Plan, have developed strong relationships with the PPO participating providers while simultaneously achieving millions of dollars in FEHB Program benefits savings. OPM Director King recently hailed this "managed care" infrastructure as a driving force in the FEHB Program's success in controlling premium costs. Yet the Administration proposes to disrupt the well-established, cost-effective doctor/patient relationships which that infrastructure has fostered by disbanding the FEHB Program and replacing it with a system which, even at its most generous, leaves SAMBA Plan members with less coverage than they enjoy currently.

This painstakingly-constructed managed care infrastructure, however, only tops the list of investments and improvements that would be irretrievably lost if the Administration's proposal to abolish the FEHB Program is enacted. In recent years, OPM has implemented a number of other cost saving measures which have made the FEHB Program the successful model it is widely recognized as today. Those measures include, but are not limited to, the following:

1. Benefit Cost Management Improvements: FEHB Plans are currently compiling benefit claims and demographic data which OPM will use to track utilization trends and patterns both across the entire FEHB Program and by specific Plan. It is expected that OPM's management of this data will make the FEHB Program more responsive to its members' medical needs and more efficient as well.

2. Cash Management Improvements:

a. Letter of Credit System: In the last several years, OPM has implemented and refined a letter of credit system by which FEHB fee-for-service plan carriers and underwriters access Plan subscription income held in the U.S. Treasury. In that system, FEHB Plan carriers and underwriters hold a minimal amount of working capital and cannot draw down additional funds until a benefit or administrative expense check is presented for payment at the Plan's bank, meaning that subscription income stays in the U.S. Treasury for as long as possible. The Health Security Act proposes abandoning this deficit cutting mechanism.

b. Premium Tax Preemption: Since January 1, 1991, FEHB Plan carriers, underwriters, and administrators have been exempted from the burden of state and municipal premium taxes (5 U.S.C. §8909(f)), an exemption which saved the FEHB Program approximately $100 million in 1993.

c. Administrative Expense Reductions: FEHB fee-for-service plans and a small number of FEHB health maintenance organization ("HMO") plans are reimbursed for allowable administrative expenses subject to an annual cap. Since January 1, 1988, OPM has adjusted the manner in which that cap is calculated, and by doing so has been able to negotiate reductions in the administrative expenses for which those plans are reimbursed in a given year. Eliminating the FEHB Program would mean ceding that negotiating authority to the regional alliances.

d. Quality Assurance Initiatives: OPM currently has a number of quality assurance initiatives in place which meet or exceed those that would exist under the Health Security Act. For example, OPM is authorized to take action to protect FEHB enrollees when it learns of a "significant event" which may impact the Plan's ability to service its membership, or when it detects a material deficiency in a Plan's

ability to do so. OPM also has established minimum quality assurance requirements which each FEHB Plan must meet, and it can order a Plan to correct a program which it determines is deficient in some respect. OPM's dispute resolution procedure (described at 5 C.F.R. §890.105) has streamlined enrollee appeals of disputed benefit claims and reduced the frequency and cost of litigating FEHB Plan benefit decisions. Finally, not only do FEHB Plans no longer cover charges for services rendered by providers who have been debarred or suspended from the Medicare program, OPM's Office of the Inspector General has created a unit which investigates FEHB Program fraudulent activity generally. By disbanding the FEHB Program, OPM would in essence cede control to the States of these quality assurance issues which affect federal employees.

3. Electronic Connectivity: OPM currently is sponsoring an automated pilot project whose goal is to simplify the process of reconciling Government payroll office and Plan office enrollment information. In addition, with OPM's encouragement, FEHB Plans are increasing the number of benefit claims received electronically. An increase in the amount of enrollment and claims information that is transmitted electronically will increase Plan responsiveness to its membership, which ultimately will reduce FEHB Program administrative costs even further.

The Administration's proposal ignores not only these significant achievements, but the substantial investment of Federal Government and employee funds which went into accomplishing them. Considering that these achievements have effectively reduced the cost to federal employees of purchasing health coverage, SAMBA considers it ill-advised to make federal employees once again foot the bill while the regional alliances have to reinvent the cost containment wheel.

The Health Security Act, however, all but concedes that federal employees will be stuck with a sizable portion of that bill. Title VI, Subtitle A of the Act, which contains the formula to be used each year by the National Health Board (the "Board") to decide where to cap the premium which each regional alliance charges, states that the principal component of that formula, "national average per capita current coverage health expenditures," shall include as one of its elements an estimated percentage (determined by the Board but no more than 15 percent) that reflects the proportion of premiums that are required for health plan and regional alliance administration (including regional alliance costs for administration of income-related premium discounts and cost sharing reductions) and for State premium taxes. (Section 6002(b)(2)(D), p. 977). In other words, the President's proposal assumes that as much as $15 out of every $100 in premiums which the regional alliances receive will go to pay administrative expenses and State premium tax assessments, a remarkable fact considering that in his September 22, 1993, speech to the American people explaining the guiding principles of the Health Security Act, the President pointed to excessive administrative expenses as one of the major causes of health care cost increases, and indicated that his proposal would achieve significant savings in that area. Even though this 15% figure appears to represent the Administration's estimate of the most the regional alliances will incur in combined administrative expenses and State premium tax assessments, if past experience is any guide, that estimate may well become the standard, not the ceiling.

By way of comparison, under Section 8909(b) of the Federal Employees Health Benefits Act, the U.S. Office of Personnel Management retains 4% of premiums paid. OPM currently uses approximately one-tenth of those retained premiums to cover its costs of administering the FEHB Program, and devotes the remaining nine-tenths of those retained premiums to a contingency reserve out of which health benefits payments are made in certain enumerated situations.

In addition, the SAMBA Plan, like all FEHB Plans, is exempt from State premium taxation (see 5 U.S.C. §8909(f) referenced above at page 12), while its administrative expenses total only about 4% of premiums actually received. In other words, the SAMBA Plan returns approximately 96% of subscription income to its membership in the form of cost containment and health benefits payments. This pattern is typical of the FEHB Program as a whole, where administrative expenses total less than 10% of premiums received, with the test going to pay benefits. In short, the administrative cost savings which the Administration has hailed as one of the Health Security Act's most unique features already exists in the FEHB Program, and to a far greater extent than envisioned in that legislation. SAMBA cannot see how the Administration's unsubstantiated political concerns would be advanced by sacrificing a health benefits program which provides quality coverage to over 10 million people on the same terms as, and at a lower cost than, those envisioned in the Health Security Act.

Another aspect of the Health Security Act which troubles SAMBA is the absence, as this Committee has recognized, of a requirement that OPM either offer a supplemental benefit plan to federal employees or make a Government contribution toward

the premium of such supplemental plans if they are established. This means that federal employees who wish to keep the same level of coverage they have currently will have to pay 100% of the additional cost of doing so. Obviously, whatever up-front premium savings federal employees may realize from an increased Government contribution towards the purchase of coverage from a regional alliance will be more than offset by the back-end cost of this supplemental coverage.

In addition, it is self-evident that the people who are most likely to purchase supplemental coverage to replace the coverage they will have lost under the Health Security Act will be those who need it the most. Therefore, these supplemental plans will be a prime target for adverse selection because their membership will consist almost entirely of people who will utilize that additional coverage extensively. As a result, these supplemental plans will either collapse of their own weight, or the cost of joining one will skyrocket to the point where the people who most need that supplemental coverage will be the ones who are least able to afford the sizable premium needed to purchase it.

Furthermore, in our opinion the Health Security Act presents a serious financial threat to a Federal Government already burdened with excess debt. As the Committee is aware, the Health Security Act generally caps the premium obligation of a private sector employer who participates in a regional alliance at 7.9% of its wage base. However, the Act does not extent this cap to governmental employers until 2002, four years after the FEHB Program's scheduled dissolution (Section 6123(a)(2), pp. 1051–1052). Although the Federal Government's contribution to the FEHB Program currently totals less than 7.9% of its wage base, several studies, including one conducted by the Congressional Budget Office, have pointed out that under the untried employer contribution formula proposed in the Act, the Federal Government's contribution during that period may well exceed 7.9% of its wage base, which in turn would increase pressure on Congress to reduce other elements of the federal workforce compensation package. New York and California state governments have already cried foul against this inequity.

SAMBA's purpose in raising these objections is not to imply that the FEHB Program is perfect in every respect. Like all programs, it undoubtedly could be improved. However, it is a proven, efficient, and economical health care protection program that does not deserve to be discarded in favor of the Health Security Act's untested regional alliances.

In sum, our analysis leads us to the unavoidable conclusion that neither SAMBA's membership, nor federal employees as a whole, will "fare well" under the Health Security Act as it is currently written. The federal law enforcement community, like all federal and other employees, deserves to have quality health coverage available to it at a reasonable cost. Currently, under the FEHB Program, it does. What the federal law enforcement community does not deserve is less coverage at greater cost, as the Administration's proposal would have it. Therefore, it is SAMBA's opinion that the FEHB Program which the President, the First Lady, this Committee, and various others have identified as a "good model" for health care reform should be preserved as part of the Administration's health care reform effort. Whatever questionable political purpose might be served by its dissolution cannot justify the hardship to SAMBA's members particularly, and federal employees generally, which would be the inevitable result of that action.

As a final matter, SAMBA applauds the Chairman's and this Committee's success in convincing the Administration to preserve the FEHB Program until all of the regional alliances contemplated under the Health Security Act have been established. However, we remain concerned by the fact that the Act would terminate the FEHB Program on December 31, 1997, even if all of the regional alliances have not been established by that date. If the FEHB Program *is* ultimately terminated, the Act should at least be amended to require that it stay in effect until December 31 of the year in which all the regional alliances have become fully operational, and have been proven effective.

Mr. Chairman, I thank you for holding these hearings and for giving me the opportunity to present SAMBA's views on H.R. 3600, the Health Security Act of 1993. While SAMBA supports some of the principles which the Administration espouses in that Act, it firmly believes that those principles are best advanced by preserving, not abolishing, the FEHB Program. SAMBA looks forward to working with you, the Committee, and the Administration to ensure that the federal law enforcement community is well served by the health care reform which ultimately does occur.

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Comparison of 1994 Standard Option Annual Premium & Employee Portion with CBO Estimate of Clinton Plan

	1994 Standard Option		**CBO Estimate 1994 Clinton Proposal**
National	Premium		Premium
SOS	$2,179.80	Single	$2,100.00
SOF	$4,860.24	Two Parent Family, Children	$5,565.00

Employee's Out-of-Pocket Costs for Inpatient Charges in 1994 Dollars

Diagnosis	Estimated 1994 Charge	BCBSA Standard Option PPO	BCBSA Standard Option Non-PPO	Proposed Guaranteed National Benefit Package* Low Cost-Sharing	High Cost-Sharing	Combination In-Network	Combination Out-of-Network
Normal Delivery							
Hospital	$5,000	$0	$250	$0	$1,000	$0	$1,000
Physician	$2,500	$315	$775	$0	$500	$0	$500
Total	$7,500	$315	$1,025	$0	$1,500	$0	$1,500
Heart by-pass Surgery							
Hospital	$25,000	$0	$250	$0	$1,500	$0	$1,500
Physician	$9,500	$665	$2,525	$0	$0	$0	$0
Total	$34,500	$665	$2,775	$0	$1,500	$0	$1,500

* Out-of-pocket costs reflect those for an individual only. Families may incur up to an additional $1,500 in out-of-pocket costs for a second individual.

ISBN 0-16-046076-X